

This electronic thesis or dissertation has been downloaded from the King's Research Portal at <https://kclpure.kcl.ac.uk/portal/>



**Becoming a medical educator
Understanding a complex professional identity**

Horsburgh, Joanna

Awarding institution:
King's College London

The copyright of this thesis rests with the author and no quotation from it or information derived from it may be published without proper acknowledgement.

END USER LICENCE AGREEMENT



Unless another licence is stated on the immediately following page this work is licensed

under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

licence. <https://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to copy, distribute and transmit the work

Under the following conditions:

- Attribution: You must attribute the work in the manner specified by the author (but not in any way that suggests that they endorse you or your use of the work).
- Non Commercial: You may not use this work for commercial purposes.
- No Derivative Works - You may not alter, transform, or build upon this work.

Any of these conditions can be waived if you receive permission from the author. Your fair dealings and other rights are in no way affected by the above.

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

**Becoming a medical educator:
understanding a complex
professional identity**

Submitted for the degree of
Doctorate in Education

Joanna Horsburgh

School of Education, Communication and
Society

Kings College, London

May 2018

Abstract

In the last 10-15 years there has been a significant increase in the number of medical doctors completing Master's level qualifications in education. This Research Based Thesis (RBT) aims to explore the professional identity development of these individuals who work across the differing communities of practices (Wenger, 1998) of medicine and education. This thesis explores the diverse nature of both the medical and educational practices that these participants engage in and how this impacts on their identities as medical educators. In particular, it aims to explore the similarities and differences between different groups of medics in how they develop their medical educator identity including how participants from different specialities broker their identity between different communities of practice. Some of the key factors that are influential in the shaping of professional identity of medical educators are thereby explored. In particular, gender is used as a lens through which to explore issues of power and hierarchy that may impact on identity development.

Drawing upon a social constructivist approach, 15 semi structured interviews were conducted with clinically qualified medical educators all of whom had completed, or nearly completed, a Master's in Education (MEd). The interviews were audio recorded and transcribed prior to being thematically analysed (Corbin and Straus, 2015). An orientation exercise was also undertaken in which medical Royal College websites and education articles within medical journals were analysed to better understand the values and assumptions about education that were presented within a small selection of medical specialties.

The key findings focused around the diversity of education activities that participants engaged with including how these activities were viewed by others as both low and high status. Participants often experienced tensions in brokering between education and medicine communities, and these tensions ranged in type and complexity given differences between and within these communities. Some factors that impacted on participants' medical educator identity included how integrated their education and medicine roles were, completion of their MEd qualification and how this was viewed by others, the amount of identity capital they held, and issues around gender.

This research shows how developing a professional identity as a medical educator is complex and challenging.

Acknowledgements

I would like to thank the participants who gave up their time to take part in this study and who were so thoughtful and insightful in their reflections about their development as medical educators. Sincere thanks to my supervisor, Prof Alan Cribb, for his expert guidance and continual encouragement and support. Thanks also to Dr Sara Donetto who supported some of the early parts of this research and helped guide some of my initial thinking

Completion of this thesis would not have been possible without the support of my fellow EdD students - Ann, Louise, and Jenny. Thank you for your continued support and encouragement. Furthermore, I would like to thank my colleagues in the Education Development Unit at Imperial College London. In particular, Prof Martyn Kingsbury for providing me with support and time to complete the writing up of this work; Aoife McCarthy for practical help in recruiting participants; Dr Dave Riley for helpful discussions on all things identity related; and my colleague and friend, Kate Ippolito for her endless encouragement and enthusiasm.

Finally I would like to thank my family – Mum, Dad, Abi, Kenny, Nic, Emma, Ruby and Maya. I am indebted to them for their unwavering love and support.

Table of contents

	Page no.
Abstract	i
Acknowledgements	ii
Table of contents	iii
List of tables	vi
List of figures	vi
List of abbreviations	vii
Chapter 1 Introduction	
1.1 Focus and rationale	1
1.2 Context of the Research Based Thesis	4
1.3 Research aims and questions	8
1.4 Structure of thesis	8
1.5 Conclusion	9
Chapter 2 Review of the Literature	
2.1 Introduction	10
2.2 Defining medical educators	10
2.3 Development and professionalisation of medical educators	13
2.4 Professional identity development in medical education	15
2.5 Communities of Practice as a theoretical framework	18
2.6 Medical education, prestige and the hidden curriculum	26
2.7 Gender and medical education	29

2.8 Conclusion	38
Chapter 3 Methodology and Methods	
3.1 Introduction	39
3.2 Methodological approach	40
3.3 Setting and context	41
3.4 Recruitment and negotiating access	43
3.5 Ethical issues	45
3.6 Interviews	48
3.7 Data analysis	55
3.8 Participants	57
3.9 Conclusion	64
Chapter 4 Results	
4.1 Introduction	65
4.2 Medicine as a constellation of communities	65
4.3 Education as a constellation of communities	73
4.4 Crossing paradigms – the work of identity development and the impact of studying a Master’s in Education	78
4.5 Status and prestige of education	91
4.6 Gender differences in the identity development of medical educators	99
4.7 Conclusion	110
Chapter 5 Discussion	
5.1 Introduction	112
5.2 Diversity of practice	114

5.3 The dynamic nature of medical practice	116
5.4 Bridges over troubled water	121
5.5 Conclusion	122
Chapter 6 Conclusion	
6.1 Introduction	123
6.2 Revisiting aims and research questions	123
6.3 Contribution to theory and knowledge	125
6.4 Contribution to the professional practice of medical educators	126
6.5 Limitations of the study	127
6.6 Recommendations for future research and directions	128
6.7 Personal reflections	129
References	131
Appendix 1 Research diary extracts	148
Appendix 2 Confirmation of ethical approval from King's College, London	151
Appendix 3 Confirmation of ethical approval from Imperial College, London	152
Appendix 4 Recruitment email	153
Appendix 5 Participant information sheet	154
Appendix 6 Consent form	157
Appendix 7 Interview schedule	159
Appendix 8 Example of coded interview transcript (extract)	161
Appendix 9 Example of memo	164

List of tables

Table 1 - Description of research participants	59
Table 2 – Review of medical Royal College websites	68

List of figures

Figure 1 – Tourists and sojourners in communities of practice (Fenton-O’Creivy et al, 2015)	21
Figure 2 – Factors impacting on the professional identity development of medical educators.	119

List of abbreviations

ARCP – Annual Review of Competency Progression

BMAT – Biomedical Admissions Test

BSc – Bachelor of Science

CV -Curriculum Vitae

EdD – Doctorate in Education

EWTD – European Working Time Directive

GMC – General Medical Council

GP – General Practitioner

HEA – Higher Education Academy

MEd – Master’s in Education

NHS – National Health Service

OSCE – Objective Structured Clinical Examination

PhD – Doctor of Philosophy

UKPSF – United Kingdom Professional Standards Framework

UKCAT – United Kingdom Clinical Aptitude Test

INTRODUCTION

1.1 Focus and Rationale

The aim of this Research Based Thesis is to explore the professional identity development of medical educators, specifically focusing on those individuals who have completed, or nearly completed, a Master's in Education or related sub discipline such as medical, surgical or clinical education. I have a professional interest in this area for several reasons. My background is in psychology and education and I have taught at secondary, further education and higher education levels. I have been involved in teacher education since 2004 and more recently, since 2009, in medical education. Within my current role I am involved in teaching doctors about the education and teaching of medical students and trainee doctors. This part of my professional practice ranges from teaching relatively short half day workshops focusing on '*tips and tricks*' to help support teaching generally, or a particular aspect of teaching such as formative assessment, all the way through to course leadership of a Master's in Education.

My institution focused study (IFS) explored the impact of a Master's in Surgical Education programme on the professional identity development of surgeons who were graduates of this course. This small-scale piece of research illuminated a number of issues around how these participants perceived themselves as educators, how this related to their identity as a surgeon and how their developing professional identity and engagement with education was viewed by others. These issues appeared to impact on how successfully these surgeons could cross boundaries between the two communities of practice (Wenger, 1998) of education and surgery.

As someone who is involved in faculty development and a course lead for a Master's in Education, I am interested in the impact of these courses on the identity development of medical educators and how they cross, successfully or unsuccessfully, between the different disciplines of medicine and education. As will be explained in further detail later in this introduction, all doctors are expected to be involved in the education and training of medical students, trainee doctors and colleagues (both other doctors and other allied health professionals such as nurses), but those who choose to complete a postgraduate qualification in education have perhaps demonstrated a particular level of commitment to this aspect of their role. It is becoming increasingly common for health professionals in general to undertake postgraduate study in medical or clinical education at Master's or

doctoral level (Gill et al, 2009) and this increase in the requirement for clinicians to undertake postgraduate study in education raises several questions. What are the implications of this type of study for individuals and those they work with, including both learners and colleagues? How does this postgraduate study impact on the type of roles that these individuals take on, their identity and how they negotiate possible changes in how they and others view themselves? Many of these individuals already have a higher degree in their primary medical specialty but often only minimal, if any, experience of studying education at this level (Pugsley et al 2008). How do they manage this transition between two different areas of study? My IFS also suggested that there were a number of tensions that participants managed when working within two different communities of practice particularly around how they managed their own identity and how they shared this, as well as their newly acquired knowledge and skills, with others. It is anticipated that the results of this thesis will be of interest to both medical educators (including those who have undertaken or are undertaking a Master's in Education) as well as programme leads for such courses and others who are interested in the professional development of medical educators more generally.

In recent years much research has focused on the professional identity development of medical students (e.g. Kalet et al, 2017; Monrouxe, 2009, 2010) as well as trainee doctors and surgeons (e.g. Cope et al 2016). Furthermore, there is much research that has explored the development of professional identity amongst teachers at both primary and secondary level. The argument here is that understanding identity is key to supporting the development of newly qualified teachers (Beauchamp and Thomas, 2009; Beijaard et al, 2000; Beijaard et al, 2004). In the concluding chapter of his edited book entitled 'Studying Teachers' Lives', Goodson (1992) argues that '*we require more analytical and systematic studies of teachers' lives.*' (p.234) The rationale for this is that,

'in understanding something so intensely personal as teaching, it is critical we know about the person the teacher is. Put this way it seems almost self-evident, commonsensical and so I believe it is, but the fact remains that we still have an underdeveloped literature on the personal, biographical and historical aspects of teaching.'

(P.234).

Written over 20 years ago the intervening period has resulted in much research and literature on the professional identity of teachers. However, there is little research on how the two aspects of education and medicine intersect within the professional identity of medical educators. With the increase in postgraduate courses in education aimed at

medical educators as well as changes in the curriculum of both undergraduate medical students and postgraduate trainee doctors (Lewington, 2012), placing increasing demand on medical educators, this seems a pertinent opportunity to examine this issue in more detail. Indeed, Starr et al (2003) suggest that strong educator identities are needed to help facilitate recruitment and retain good medical educators. Therefore, exploring the professional identity of these individuals and in particular, factors which support and diminish their identity would be important in developing practical strategies related to the recruitment and retention of effective medical educators. This has come to the fore with the changes in wider higher education policy for example, an increasingly neoliberal approach to the marketization of higher education with the increase in tuition fees for students (Molesworth et al, 2011) as well as the introduction of quality assurance measures such the Teaching Excellence Framework (Department for Business, Innovation and Skills, 2016).

At this stage, it is worth highlighting that the term '*medical educator*' is used in several different ways both within the literature and by those working in both medicine and education. For some it refers to anyone involved in teaching medical students and doctors, including someone, like myself, who is not medically qualified themselves. For others, the term only refers to those who have a specific named role within medical education such as a course lead for an undergraduate medicine programme, often undertaken at the exclusion of, or at least reduction in, pursuing or continuing a clinical career. For the purposes of this thesis, the term refers to anyone who is medically qualified and has completed or is near completion of a Master's course in education or specifically medical, surgical or clinical education. This is for both practical and theoretical reasons. As previously discussed, and as will be explored further within the literature review, there is limited research into the professional identity development of medical educators and given the increase in the number of such Master's courses it seems pertinent to consider the impact that these programmes have on those who undertake them. Furthermore, the size and scope of this thesis means that limiting the sample to a specific group within medical education has resulted in a more manageable approach, better suited to the nature of an EdD thesis. Limiting the sample size also means that comparisons can be more easily made between participants.

1.2 Context of this Research Based Thesis

Outlining the context of medical education in the United Kingdom is intended to orientate the reader to the various pathways to becoming a qualified doctor, as well as the expectations and requirements for doctors to be involved in the teaching and education of medical students, colleagues and other health professionals. As well as outlining this context, I will also briefly consider the development of medical education as a discipline area and describe my own background, context and professional interests. My role as a researcher and the approach that I adopted for this piece of research will be discussed in further detail in the methodology section of this thesis.

Undergraduate and postgraduate medical education

At the undergraduate level, most medical students enter medical school post A level or equivalent (e.g. International Baccalaureate) at the age of 18, although some medical schools offer graduate entry courses for those who already hold a first degree, normally in a science or related discipline. Most undergraduate medical degrees are between 4 and 6 years with some providing students with the opportunity to undertake an intercalated BSc degree or PhD. There are currently 34 higher education institutions in the UK who offer medical degrees (Medical Schools Council, 2016a). Entry to medical school is competitive with students typically requiring a combination of A and A*s at A level as well as at GCSE level. Applicants are also required by most medical schools to take an aptitude test, either the Biomedical Admissions Test (BMAT) or UK Clinical Aptitude Test (UKCAT), as well as work experience in a healthcare setting or other caring or service role (Medical Schools, Council, 2016b)

Once graduated from medical school, trainee doctors undergo many years of further training before qualifying as a consultant doctor in a chosen specialty. During this time, they are often referred to as junior or trainee doctors (Baddeley, 2017). This training is initially general and broad-based before doctors choose to specialise in an area of medicine or surgery (BMA, 2017; Greenway, 2013). This initial training involves two years of generic training (referred to as the Foundation Programme) during which doctors rotate through a range of medical and surgical specialties (UKFPO, 2017). Doctors then choose to specialise in medicine, surgery, psychiatry or general practice during their core training years which lasts two to three years. Further specialism follows with trainee doctors choosing to specialise in a particular area such as dermatology, old age psychiatry, cardiothoracic

surgery etc. This higher training (during which doctors are often referred to as registrars or specialist trainees) can last up to six years, although many choose to undertake out of training programme activities such as completion of a higher degree or other research, or take on a specific leadership or educational role. Without taking account of these out of training activities, training to become a consultant can last up to 10 years during which doctors are also expected to successfully complete various examinations and other continuing professional development activities (RCP, 2015).

Doctors as educators

Historically, doctors have always been involved in the education and training of others (Shepherd et al, 2010). The apprenticeship model was prevalent up until reforms such as Modernising Medical Careers (Department of Health, 2004) which introduced changes to postgraduate training for doctors, the European Working Time Directive (EWTD), limiting the number of hours that doctors could work (de Cossart and Fish, 2005), and reforms to undergraduate education by the General Medical Council (GMC) have made these requirements more specific and explicit (GMC, 1993; 2009; 2015a; 2015b). Within undergraduate medical education the General Medical Council (GMC) sets the standards and requirements that medical schools must meet in order to award medical degrees. They also stipulate the outcomes that students should have achieved by graduation, including the requirement to teach. In relation to this aspect of professional practice, the GMC (2009) states that medical students should be able to '*reflect, learn and teach others*' (p.26). More specifically the GMC standards refer to students being able to,

'Establish the foundations for lifelong learning and continuing professional development, including a professional development portfolio containing reflections, achievements and learning needs.

Function effectively as a mentor and teacher including contributing to the appraisal, assessment and review of colleagues, giving effective feedback, and taking advantage of opportunities to develop these skills.'

(p.27)

Often medical students will receive formal sessions on how to teach but in addition may set up their own peer teaching sessions where students from older years teach younger students, as well as organise their own revision courses. Some medical schools also offer students the opportunity to undertake short modules in medical education or even a complete an intercalated BSc degree in medical education (van Winsen et al, 2017).

As well as requirements for medical students, the GMC has specific requirements for those involved in their education. Specifically, the GMC (2015a) states that,

'Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.'

Educators (should) receive the support, resources and time to meet their education and training responsibilities.' (p.29)

This involves these educators having sufficient time and resources to educate medical students and also that the medical schools should provide appropriate training and support for these individuals, although it is up to individual institutions to decide how this is designed and delivered. As well as these more overarching standards, the GMC also stipulates specific requirements for those who have a defined and named role, either within postgraduate or undergraduate education. This means that those who have the postgraduate roles of being a clinical or educational supervisor for trainee doctors, and those within undergraduate education who are lead coordinators of education at a specific site, or who have a specific role in overseeing the progression of medical students, require additional recognition by the GMC.

Alongside the GMC requirements, those involved in medical education at university level may also be impacted on by wider higher education policy. With the introduction of the Teaching Excellence Framework (Department for Business, Innovation and Skills, 2016) there is increasing pressure on universities for teachers to be qualified with the introduction of the Higher Education Statistics Authority (HESA) collecting data from each higher education institution on the number of qualified teachers.

The development of medical education as a discipline area

As referred to in the 'Focus and rationale' section, the term '*medical education*' is not well defined (Sabel and Archer, 2014) both in the literature and in practice, and is often used in several different ways. Firstly, it can be used to describe the learning and development that medical students and postgraduate trainees go through to become fully qualified medical doctors. Secondly, the term is also used to denote a specific discipline area that focuses on the study and research of these processes. Many medical schools have a department of medical education to undertake this study and research, as well as focusing on the development of curricular and assessments. Finally, whilst it is clear that all doctors are (or at least should be) involved in the teaching and training of others and therefore all might be considered to be medical educators, in recent years this separate discipline of medical

education has developed (Tucker, 2017) with some professionals identifying themselves more as having a role in medical education. These professionals may also include those who come from a non-medical background such as nurses, or who have an education background, but who are all involved in the development and training of medical students and doctors.

However, there is some dispute over whether medical education is a separate discipline (Tucker, 2017) or a collection of theories, concepts and practices drawn from other education related areas (Cristancho and Varpio, 2016; Swanick, 2014,). Sethi et al (2016) argue that medical education is a separate discipline area due, in part, to increased quality assurance and regulatory processes, a point which Swanick (2009) also agrees with. Bannard-Smith et al (2012) also argue that medical education, as a separate speciality, is becoming more formalised and professional with increased expectations from both students and trainee doctors regarding the quality of educational experiences that they receive. As a result, there are now specific medical education membership organisations, for example the Association for the Study of Medical Education (ASME), a UK based organisation set up in 1957 in response to the liberalisation of undergraduate medical education within the UK by the General Medical Council (ASME, 2007) and the Association for Medical Education, Europe (AMEE) set up in 1972 (Wojtczak, 2013). Both support those involved in medical education including doctors, students, researchers, administrators and so on, through holding annual conferences, publishing medical education journals and providing grants for research and professional development.

My role within medical education

I have worked within medical education for the last nine years in two different institutions, having previously taught in secondary and further education. Much of my own development as a medical education has been '*on the job*' in that my appointment at the first of these institutions did not require any specific experience in medical education or understanding of a medical context. Whilst my medical knowledge is therefore limited, I have some understanding of the context within which medical education takes places, at both undergraduate and postgraduate levels, and am familiar with the technical language and abbreviations often used. Finally, as part of my current role I am a course lead for a Master's in Education course. Whilst not specifically focused on medical or clinical education, approximately half of the students enrolled on the course are medical doctors. This is a part time course, normally completed alongside a full-time job. Students on the

course are required to be involved in teaching students, with most having some designated role such as responsibility for a specific area of the curriculum e.g. as a module lead, or have a pastoral or student support role e.g. head of year.

1.3 Research Aims and Questions

Having considered the focus and rationale for this research, as well as the context within which it takes place I will now discuss the aim and research questions for this piece of work. Building on from my institution focused study, the aim of this thesis is to explore the ways in which medics (surgeons, psychiatrists, physicians, general practitioners etc.) who are graduates of or currently completing a Master's in Education course, develop and negotiate their professional identity. Specifically, the research questions for this work are:

1. How do medics develop their medical education identity and what may be the similarities and differences between different groups of medics (surgeons, psychiatrists, physicians, general practitioners etc.) in this respect?
2. How do different participants (reflecting a range of specialties) broker their identity between the different communities of practice of medicine and education?
3. Based on these experiences and comparisons, what factors appear to be influential on the shaping of professional identity of medical educators?

1.4 Structure of Thesis

The structure of this thesis is divided into several chapters and sub-sections. Chapter 2 is the literature review and will consider the existing research and literature pertaining to this area. This will include existing literature on the professional development of medical educators and consideration of the existing theoretical work on identity development and in particular, professional identity development. I will discuss the theories used to frame this work, namely communities of practice (Wenger, 1998). I will also consider the existing literature on how gender differences impact on medical education. Chapter 3 outlines the methods and methodological approaches to this research. In this chapter I will also outline and justify the choices of data collection methods and analysis. Issues pertinent to ethics, participant selection and recruitment will also be discussed in detail. Chapter 4 will present the key results and discuss these using illustrative quotes from the participant interviews. I will also discuss these findings in relation to the previous literature in chapter 5 and draw together the key conclusions and implications for theory and practice.

1.5 Conclusion

This introduction chapter has discussed the rationale for this thesis including the increase in the professionalisation of medical educators and the focus on those medics who have completed a Master's in Education. The wider context for this work, including the nature of both undergraduate and postgraduate medical education, the development of doctors as educators and medical education as a discipline has been set out. This chapter concludes by considering my own professional context within medical education, the aims and research questions for this work, as well as the proposed structure.

The following literature review chapter will discuss the existing literature, both theoretical and empirical, on the professional development of medical educators. It will focus specifically on how the theory of communities of practice (Wenger, 1998) may be used to frame this research as well as aspects that this theory has overlooked that may be key factors in the development of professionals in this area.

LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to critically consider a range of literature, both theoretical and empirical, that is relevant to this research project. Firstly, I will consider the role of medical educators and how they are becoming increasingly professionalised. Secondly, I will consider some of the literature relevant to identity development and specifically, the development of professional identities. I will discuss the work of Wenger (1998), and the theory of Communities of Practice as an explanation of how individuals may develop professional identities and as one way in which to frame this work. In particular, I will draw upon the concept of brokering, which Wenger defines as working across different communities of practice. Wenger acknowledges that brokering is complex but also that it is a role where much learning can take place. This complexity is particularly significant within medical education because of issues of power, prestige and hierarchy which, it is argued, the theory of Communities of Practice does not sufficiently acknowledge (Contu and Willmott, 2003; Kerno, 2008; Roberts, 2006). I will use gender as a lens through which to illuminate and explore these particular issues further. The reasons for this choice of lens will be discussed later in this chapter.

2.2 Defining Medical Educators

Building on the discussion in section 1.2 of the Introduction, this section will further define and explore the characteristics of medical educators, drawing upon existing empirical research and policy documents. Firstly, in terms of defining medical educators, Steinert (2014) suggests that there is no clear definition and that the terms '*medical educator*' and '*medical teacher*' are often used interchangeably. Indeed, as was suggested in the Introduction chapter, a range of different professionals are involved in medical education at all levels and may all have claim to the term '*medical educator*'. However, in trying to define medical educators, Steinert interviewed colleagues involved in medical education to seek their views on the roles and characteristics of medical educators. The common themes included being able to reflect on the educational experiences of students, educational innovation, having more than just an interest in education (e.g. '*passion*'), and using educational theories and principles to underpin their practice. Steinert argues that what is striking about her findings,

'is the emphasis on reflection, passion, innovation and informed practice, across a continuum of tasks and activities.'

(p.456)

Several professional organisations, such as the Higher Education Academy (HEA) and the Academy of Medical Educators (AoME), propose professional standards for medical educators including areas of activity that medical educators should be involved in and the core values that they should espouse, which may be helpful in defining the role and characteristics of medical educators. The HEA, for example, helped to develop the UK Professional Standards Framework (UKPSF) which, they argue is a '*nationally-recognised framework for benchmarking success within HE teaching and learning support*' (HEA, 2011). The framework consists of 15 standards, divided up into areas of activity such as planning teaching and assessment and feedback, core knowledge, including knowledge of how students learn within a subject area, and professional values such as equality of opportunity for learners in higher education. The Academy of Medical Educators presents similar standards but for those specifically working within a medical education context (Academy of Medical Educators, 2014). Therefore, these standards could be used to help define those who are considered to be medical educators.

Despite these common standards, it is evident from published research that medical educators come from a range of professional backgrounds (Hu et al, 2015). An international survey by Huwendiek et al (2010) found that 68% of medical educators came from a medical background, 12% from an education background and the remaining 20% from basic sciences, psychology and other health professions backgrounds. Relatively few had formal postgraduate qualification in education, with 16% of respondents having a Master's qualification in education, and 7% having a PhD in education. Hu et al (2015) suggest that although many of those involved in medical education value the variety in the role,

'they lack a sense of group identity or even of a future career in education. The demands of academia to do research may sit uncomfortably with those who see their calling as being teachers, leading to such institutional obligations being called 'inauthentic'.'

(p.1125)

Participants in Hu et al's study (early career medical educators and senior academics with expertise in medical education) saw diversity of backgrounds as a positive attribute of medical education but there was disagreement about who should be classified as a medical educator. For some, it was anyone who was involved in the teaching of medical students or doctors, whilst for others it was those who had particular expertise or qualifications. For

some the distinction went further, with some participants classifying only those who researched the teaching and learning of medical students as medical educators

Hu et al (2015) also pointed to the '*invisibility of medical education*' (p.1129) arguing that this makes it difficult to define who medical educators are. They suggest that an,

'absence of a common professional origin and a poorly delineated scope of activities with largely intangible and symbolic rewards, led to a perception of medical education practice being neither unique nor distinctive. It lacked visibility as a practice and as a career.'

(p.1129)

For many medical educators in Hu et al's study (as well as in other studies such as Sabel and Archer, 2014) there was no defined career path and that they often became involved in medical education serendipitously. One of the challenges of developing and sustaining a career in medical education was the perception that financially, in terms of salaries and research funding, medical education could not compete with clinical specialities. Furthermore, those medical educators with clinical backgrounds were seen as having more professional credibility and participants in Hu et al's study reported continuing with clinical activities in order to maintain this.

One short term career option for those with an interest in medical education is the increase in clinical teaching fellowships offered by medical schools, hospital trusts or professional organisations (Furmedge et al, 2013, Roberts et al, 2014,). Clinical teaching fellow posts provide named individuals within a hospital or medical school who have responsibility for teaching medical students, or for an area of curriculum development or assessment. These post are often aimed at trainee doctors, normally lasting for one to two years and cover a range of different teaching and broader educational activities. For example, a teaching fellow may be primarily involved in teaching their own speciality or more generic clinical skills, particularly if they are based within a teaching hospital. If they are based within a medical school or academic department then there may be greater emphasis on the development of curricular, writing exam questions or designing and creating learning resources (Roberts, et al 2014, Wilson et al, 2008). Drivers for such post include the introduction of standards for undergraduate medical schools brought in by the GMC and changes in working practices within medicine, such as changes in shift patterns and the European Working Time directive (Wilson et al, 2008). In some circumstances such experience may enhance an individual's curriculum vitae (CV) (Wilson et al, 2008) and demonstrate commitment to this particular aspect of their professional role. Clinical

teaching fellows have also reported enjoying interacting with students, developing their own knowledge, and having the opportunity to develop their skills in new areas such as curriculum planning (Wilson et al, 2008).

The reported disadvantages of such fellowships include time away from clinical work and the risk (or perceived risk) of losing clinical skills. Teaching fellows may also have unrealistic expectations about undertaking educational research within their fellowship particularly if their fellowship time limited. Often, they are unfamiliar with the research methods, normally qualitative, that are more often used in educational research. Furthermore, applying for and gaining ethical approval is often more time consuming than sometimes anticipated (Qureshi, 2015). The risks and benefits of these types of post are likely to mirror those which all medical educators experience.

2.3 Development and Professionalisation of Medical Educators

However, despite the range of views about who should be considered a medical educator there is an increasing professionalisation of teaching within medical education and as well as across higher education more broadly. Previously, a commonly held belief was that qualifications, as well as experience of learning and practising medicine, were sufficient to teach medical students (MacDougall and Drummond, 2005). McAvinia et al (2015) identify some of the drivers for this increase in professionalisation, including the body of research evidencing the limitations of more traditional, conventional methods of teaching, the increase in the use of eLearning and technology in higher education teaching, and concerns about student retention. Medical educators are now expected to be curriculum designers and organisers as well as teachers (Boerboom et al, 2009). Furthermore, developments in higher education policy have increased the number of professionally accredited course for those working in higher education (Schofield et al, 2010). For example, the Dearing Report (NCIHE, 1997) recommended that higher education staff should undertake formal courses in teaching and learning. However, in a Higher Education Academy (HEA) review, Parsons et al (2012) suggest that in most European countries at least, there is no requirement for teachers in higher education to hold a teaching qualification, although participation in faculty development activities is often required of newly appointed or probationary lecturers. However, compulsion for all to take part in these development activities and achieve a teaching qualification may change in light of the introduction of the Teaching Excellence Framework (Department for Business, Innovation and Skills, 2016).

The impact on the practice of higher education teachers who have completed a postgraduate qualification in education has included new approaches to teaching, being more confident in these methods, taking an approach that was more student-centred and engaging in discussions and dissemination across departments and the institution (Burcher and Stoncel, 2011). It was also found in Burcher and Stoncel's study that participants with such a qualification had an increased level of credibility within their departments. For example, one participant commented that,

'I feel I'm more credible now that I've actually got the teaching qualification – and the way people respond to me is different – a lot will come and ask for advice and support.'

(Burcher and Stoncel, 2011. p.156).

However, these were participants in a post-1992 teaching led university who had come to working in higher education via a professional route rather than a PhD and were working in departments where pedagogic research was valued. Indeed, Burcher and Stoncel comment that the modelling of effective teaching practices in this PGCert may be more closely aligned with their participants than with those working within research intensive institutions and therefore these findings may not be transferable to a research-intensive context.

Nevertheless, similar findings were shown in a study by Gibbs and Coffey (2004) who researched participants from across 20 universities, including research intensive universities. They also found that participants took a more student-centred approach to their teaching practice, as well as becoming more confident in their practice. This increased focus on student centred learning was also highlighted by Hanbury et al (2008). Gibbs and Coffey also reported that these changes in teachers' practice impacted on students in the way in which they adopted a deeper approach to their learning. Other benefits of engaging with educational CPD activities included finding and engaging with likeminded colleagues, developing confidence in their teaching and enhancing students' learning (McAvinia et al, 2015), better understanding of how students' learning could be improved (Weurlander and Stenfors-Hayes, 2008), and a more positive attitude towards teaching generally (Steinert et al, 2006).

Alongside the GMC requirements for some medical educators to be officially accredited, there is an increasing demand for doctors to have postgraduate qualifications in education (Swanick, 2009), driven by an increase in student numbers and significant reviews of both postgraduate and undergraduate medical curricular (Hu et al, 2015, Stoddard and

Brownfield, 2016). In 2005, Cohen et al identified 21 Master's in education programmes (internationally) for doctors and other health professionals, whilst by 2012 this had increased to 71 Master's level programmes in health professions education (Tekian and Harris, 2012). Commonalities between these programmes included similar content and educational requirements, whilst differences included the ways in which courses were structured and organised, such as different module combinations and modes of delivery (face to face and online). For those specifically interested in medical education, studying for a postgraduate qualification in this area demonstrates this interest, as well as their commitment (Bannard-Smith et al, 2012). Research suggests that there are various benefits of such programmes to medical educators including self-reported increase in educational research and scholarship which was underpinned by enhanced understanding of educational theory (Sethi et al, 2016).

However, despite the increase in these postgraduate qualifications for medical educators there is no clearly defined career pathway for medical educators (Sabel and Archer, 2014) and particularly for those wanting to combine medical education and clinical experience (El-Harasis et al, 2014). El-Harasis et al go on to express their dissatisfaction with the suggestion from the Shape of Training report (Greenway, 2013) recommending that individuals interested in developing their experience and expertise in medical education, take time out of their clinical training. They report that taking time out of training is becoming more difficult for trainee doctors. They therefore call for an integrated approach to overcome these restrictions but also because they argue that non- clinical activities such as teaching, research and management are important for high quality patient care. There appears to be a tension here between the requirement (as stipulated by the GMC and other organisations such as the British Medical Association) of doctors to teach patients, students and colleagues, but little time or resource to develop skills and expertise in this area. As El-Harasis et al (2014) argue,

'clinical knowledge and expertise alone do not ensure that a doctor is an excellent teacher.'
(p.673)

2.4 Professional Identity Development in Medical Education

Having considered the variety, remit and professionalisation of medical educators, this section will consider their professional identity development. Developing as a medical educator and undertaking postgraduate study in education, necessitates development of a new professional identity. Indeed, professional identity development should be the explicit

aim of Master's level education programmes for healthcare professions (Armstrong et al, 2003, Dall'Alba, 2009, Sethi et al, 2016). In order to frame this research, as well as locate it within the wider body of literature, this section considers the current literature on professional identities, including the arguments for why it is important to consider identity development in relation to professional education.

There exists a wide range of literature and theories concerned with identity development generally as well as professional identity development more specifically. These theories range from individualistic approaches such as socio cognitive and narrative theories to social approaches such as social identity theory (Monrouxe and Rees, 2015). Early theories often considered a person's identity to be fixed, whilst later theories have focused more on the fluidity and multiplicity of identity (Monrouxe and Rees, 2015).

A useful definition of identity is provided by Gee (2001) who states that identity is,

'the way individuals understand themselves, interpret experiences, present themselves and wish to be perceived by others as well as how they are recognized by the broader community.'

(p.99)

In terms of defining professional identity development, Starr et al (2003) state that it is,

'a developmental process, during which novices acquire specific knowledge and skills, develop new attitudes and values and take on a self-concept associated with the new career role.'

(p.821)

They go on to acknowledge that professional identity is multi factorial including both internal elements such as feelings and attitudes, as well as external elements such as reward and recognition. Wald (2015) argues that the formation of a professional identity is a dynamic and active process and involves the development of an individual in the areas of *'professional values, moral principles, actions, aspirations and on-going self-reflection.'*

(p.701)

This dynamic element of identity is highlighted by Cristancho and Fenwick (2015), who suggest that the term *'becoming'* is being increasingly used to reflect the changing nature of identity. In citing the theoretical framework of Deleuze, they argue that,

'becoming is a creative process of making, remaking and unmaking oneself in relation to others...'

(p.128)

In relation to the identity development of surgeons, Cope et al (2016) suggest that,

'professional identity for surgeons is constructed or learnt through a process of negotiating one's own personal identity within the prevalent frames in the surgical community.'

(p.1)

Again, the idea that identity is constructed is drawn upon here, with Cope et al emphasising the process of negotiation within identity development, a process that will be discussed in more detail later in this chapter.

This thesis adopts the view that identity is fluid and dynamic, and developed within a social context (Monrouxe and Poole, 2013). This is because much of the previous research on medical educator identity development has focused on how the individual develops their identity through internal process such as reflection, rather than within the context of the institutions or culture within which they work (Cantillon, 2016).

Why is professional identity important?

In recent years, the concept of professional identity of medical students and doctors has gained traction within medical education (Rosenblum et al, 2016), particularly because it provides a counter narrative to the competency based agenda which can be viewed as reductionist. A more holistic approach to professional development which includes development of an individual's attitudes, values and identity rather than a narrow focus on skills and/or knowledge is becoming more prevalent (MacLure, 2001).

It has been argued that developing a professional identity is particularly important because it is linked to practising professionally and ethically. Those who see themselves as a doctor are more likely to behave in a professional way, than an individual who does not consider this to be part of their identity (Monrouxe, 2010). Furthermore, understanding professional identity is, Lomax (2013) argues, important for leaders and managers in health care settings to better support staff in delivering high quality patient care. In relation to their medical education role, Starr et al (2003) suggest that those doctors who see themselves as teachers are more likely to enjoy teaching and be regarded as effective teachers.

Therefore, considering professional identity is important in terms of recruitment of faculty and ensuring effective learning environments for students.

Despite the recognised importance of developing a professional identity, Sundberg et al (2017) argue that this process is particularly difficult for medical educators. This may be due to the relative low status of teaching compared to research, with research outputs carrying more weight (Bartle and Thistlethwaite, 2014), an issue that will be discussed in more detail in a subsequent section. Many medical educators also have competing roles (Stenfors-Hayes et al, 2010) with the overlap between these roles not always being clear (Stone et al, 2002). Stone et al (2002) identified that a lack of obvious or local medical education community could make development of an identity as a medical educator more challenging although this may well have changed, or be changing, given the intervening period since this paper.

In contrast to the research on medical educators, there is significantly more research on the professional identity development of teachers (Beijaard et al, 2004). Part of this larger body of research is, as Cohen (2010) argues, because teachers' identity is considered key to their professional practice. Consequently, understanding professional identity is key to supporting novice teachers (Beauchamp and Thomas, 2009; Beijaard et al, 2000; Beijaard et al, 2004). Therefore, an understanding of medical educators' identity is needed to support their development as they transition to working within a new discipline and paradigm.

2.5 Communities of Practice as a Theoretical Framework

As discussed in the previous section, many of the earlier psychological theories of identity do not adequately address the multiplicity of identity and consequently much of the current literature views identity as fluid, dynamic and constructed by the social context. This is the view adopted by Wenger's (1998) theory of communities of practice, which considers learning and identity as integral and proposes that individuals are continually engaged in a process of identity development through negotiation and reification. This section will therefore outline the main features of the theory, specifically focusing on participation and the practice of brokering between communities. Limitations of this theory will also be acknowledged and discussed.

This theory builds on Wenger's earlier work with Jean Lave on situated learning (Lave and Wenger, 1991) which suggests that learning can take place in contexts other than a formal classroom, such as the workplace, where it has meaning and applicability (Brown and Duiguid, 1991). Therefore, the theory of communities of practice adopts a social constructivist view of learning as Wenger argues that knowledge is contextual and learning

is about engaging with the world in a meaningful way. Learning through social participation requires ways of talking about our practice, community, identity, and meaning. Within this theory, identity and learning are considered integral to each other because,

'learning transforms who we are and what we can do...it is not just an accumulation of skills and information but a process of becoming.'

(Wenger, 1998, p.215)

Communities of practice is one of the most widely developed and researched theories and its appeal to both researchers and practitioners lies in the fact that the theory acknowledges that networks of learning may be informal as well as formal, and that there are a variety of locations where learning may take place (Barton and Tustig, 2005). For these reasons, communities of practice has been an attractive theory when considering workplace learning and the development of professionals. This theory has previously used within medical education to explore how clinicians become teachers (Sethi et al, 2017), with a focus on how this occurs within the workplace (Cantillon et al, 2016). Despite this theory being used in previous research, it still provides a useful framework to explore the complex professional identity development of medical educators.

Key features of communities of practice

Before considering communities of practice in relation to medical education, it is worth outlining the key features of the theory and consider in further detail those parts that are most relevant to this research. Communities of practice have been defined as,

'groups of people who share a concern or passion form something they do and learning how to do it better as they interact regularly'

(Wenger-Trayner and Wenger-Trayner, 2015, p.1),

and have three key components; joint enterprise, shared repertoire and mutual engagement. The term joint enterprise refers to the idea that all members of the community have a shared goal and are accountable to each other in achieving this goal. Shared repertoire is the routines, tools, language and ways of practice that the members of the community use to engage with each other. Finally, mutual engagement refers to how interactions between the community members take place and how relationships are maintained. Medicine and education may be considered different communities of practices because of differences in how these three components are expressed. According to Cruess et al (2017), the theory provides a useful overarching framework through which to consider the professional identity development of medical students and doctors because, the

authors argue, medicine is a community of practice. For example, medical doctors have the same joint enterprise, that of the prevention of disease and the treatment of those who are unwell. Within this community there are also shared practices, such as methods of diagnosis, and clinical practice as well as terminology used, in order to achieve this common goal.

As well as these three components, a further central tenant of the theory of communities of practice is the idea that learning and identity development are interlinked. As an individual learns something they change and develop their view about who they are. This is contrast to more narrow theories of learning which focus solely on learning as the acquisition of knowledge and/or skills. Wenger argues that learning is not just the acquisition of knowledge and skills but results in changes in the way in which an individual sees themselves in relation to the context or setting within which they are learning. Therefore, learning is a process of identity development and as Wenger-Trayner et al (2015) state, learning,

'is the becoming of a person who inhabits the landscape with an identity whose dynamic construction reflects our trajectory through that landscape.'

(p.19)

This idea of learning as identity transformation is not unique to the theory of communities of practice. Dall'Alba (2009a), drawing upon the work of Heidegger, argues that transformation of an individual is a key purpose of education. For example, within professional education, developing as a lawyer, teacher, or in this case, a medical educator, is *'a process of becoming.'* (p.34) Dall'Alba goes on to argue that when educators only focus on knowledge acquisition or skill development then transformation cannot be supported. However, a lack of consideration of the transformative impact of professional education programmes is not unusual (Dall'Alba, 2009b) although there is some evidence within the medical education literature that emphasis is being placed on the transformative nature of such programmes (Tekian and Harris, 2012).

Types of participation

For Wenger, identity development takes place through the process of participation and reification, and is a negotiated, lived experience. This participation may take different forms for example, an inbound trajectory where a newcomer joins a community with the aim of eventually becoming central to that community, as might happen in a typical apprenticeship model of learning. Alternatively, an individual may have a more peripheral

trajectory, either by choice or by necessity. This marginal participation, along with boundary participation, are both useful trajectories to consider further in relation to the development of medical educators. Both of these will be considered in more detail and in relation to the identity and practice of medical educators.

Peripheral or marginal participation may be experienced by those participants who deliberately choose to have this type of role. In contrast, this type of participation may also be the result of resistance or pressure from others in the community, or indeed from those in a different community (Handley et al, 2006; Wenger, 1998). Fenton-O’Creivy et al (2015) propose the metaphors of ‘*tourist*’ and ‘*sojourner*’ to account for this type of participation, whatever the reason. Both tourists and sojourner are ‘*passing through*’ a community of practice, but with low and high levels of participation respectively. Tourists engage in a relatively superficial way and their identity is unlikely to be changed as a result of the time spent within a community. Sojourners, whilst still passing through, have a high level of engagement, taking on practices of that community which will have implications for their identity development.

Participation	Imagined trajectory	
	Inside CoP	Passing through
	Low	Tourist
	High	Sojourner

Figure 1. Fenton-O’Creivy et al (2015)

This figure shows the different types of trajectory and participation that may lead to an individual taking on different roles within a community of practice. As outlined in my IFS, this resonates with my observations and experiences of students undertaking a postgraduate qualification in education. For some, the rationale for postgraduate study is strategic e.g. needed for career development, CV enhancement or because it has been deemed a requirement by their employer. As a tourist, they go through the motions, engage with the necessary tasks and assessments but there is little or no change on their identity and how they see themselves as an educator. They often need additional support or scaffolding from tutors or, at the other extreme, do not engage with tutors, missing

regular milestones. They often do not engage with the course material beyond the required reading and have more difficulty in terms of making sense of the educational content in their own context. For sojourners, they are more likely to fully engage with the process of studying for a Master's in Education, even if they do not foresee themselves as full participants of this community. However, Fenton-O'Creevy et al do acknowledge that there is no a clear division between sojourners and tourists, and that in reality, individuals may move between the two. A student may begin as a tourist before moving to a sojourner role and for some this might change to an apprentice role if they see their identity as located within this community of practice long term. For example, some of the participants interviewed for my IFS stated that they initially undertook the Master's course for strategic reasons, for example, to enhance their CV but that during the period of study took a fuller role in engaging with and participating in the course and education more broadly. Alternatively, students may start as a sojourner but work or life commitments result in them having to take a more tourist trajectory.

Boundary crossing

A second type of participation that is useful to consider is boundary participation. Many individuals engage with multiple communities and consequently cross boundaries between these communities. Learning often involves crossing boundaries between communities (Akkerman and Bakker, 2011) and for professionals, the practice of working across boundaries cannot be avoided (Wenger-Trayner et al, 2015). As a result, for some professionals who work across boundaries their identity development is located between communities rather than within communities. Brokering can be positive in that unexpected learning can occur (Wenger et al, 2002). The presence of brokers within a community can also be beneficial in that new cultures and practices are brought in from another community (Wenger, 1998). For example, doctors who had undertaken a fellowship in medical education were seen as experts in education by their medical colleagues who could add value to the medicine community of practice (Lown et al, 2009).

However, this positive outcome may not always be the case. Brokering can be a complex and challenging experience in that misunderstandings and tensions can occur as a result of a lack of shared history and values between the communities. Different communities have differing practices and make differing demands on individuals. Practices that are central to one community may not be understandable or accepted by another (Kubiak et al, 2015).

Referring specifically to the communities of surgery and education, Fry and Kneebone (2011) suggest that,

'few practitioners and scholars are fluent in the languages of both (education and surgery) and the ways of each often seem mysterious to an outsider.'

(p.6)

Therefore, those engaged in this boundary crossing experience tensions because they, according to Wenger, are engaged in a continual process of reconciliation, whereby they are attempting to make sense of, and reconcile, these differences. As Kubiak et al (2015) state,

'reconciling the demands of multimembership can require that people modulate their identification – that is, vary the strength or nature of their identification to the different communities of practice in their life.'

(p.64)

Placing oneself in the space between two communities is challenging because, in order to be accepted by both communities and therefore as an effective broker, an individual needs to yield,

'enough distance to bring a different perspective, but also enough legitimacy to be listened to.'

(Wenger, 1998, p.110)

This is particularly pertinent to those working within medical education, who risk not being a full member of either a medicine community or an education community. However, these challenges and tensions can be mitigated against. For example, social support can be vital in the effectiveness of brokering (Van de Berg et al, 2017). In their interviews of medical educators one reported receiving little social support in her role as a medical educator and that colleagues would rarely acknowledge her education work, partly because she did not think they had anything to gain from demonstrating this support. Although support was not often provided, those medical educators who did receive social support felt more confident and encouraged in terms of their medical education role and identity.

Despite these challenging aspects, Wenger-Trayner et al (2015) suggest that boundaries should be seen as a *'learning asset'* (p.18) and that they should not be hidden because this then assumes that knowledge transfer between communities is straightforward.

Medicine as differing communities of practice

As discussed previously, medicine and education may be viewed as different communities of practice which, to be effective, medical educators need to broker across. These communities have differing values, practices and ways of engagement that can make this brokering challenging. Within my institution focused study (IFS), I followed on from Fry and Kneebone (2011), positioning surgery and education as separate communities of practice which participants (who were surgeons and had completed a MEd in Surgical Education) brokered across.

Professional communities of practice are often viewed as homogenous groups with common shared repertoire, mutual engagement and joint enterprises, and indeed, there is some suggestion in the literature that medicine is a community of practice (Cruess et al, 2017). However, counter to this view Pugsley (2012) found that many ethnographic studies of professional education revealed variation within these professional communities. Within medicine there may be many communities that a clinician engages with for example the medical team that they work with (sometimes referred to as a '*firm*') as well as a wider community of junior doctors. They may also engage with other communities of practice if they work at a medical school or teaching hospital (Cantillon, 2016). Different medical specialities may also be considered different communities of practice. For example, the practice of a surgeon is very different from that of a psychiatrist in terms of the mode of practice, how they engage with patients and the language used. Different specialities also experience differing level of status which sets them apart from each other. For example, Baszanger (1985) reported general practitioners feeling marginalised from hospital medicine which they thought was considered as more mainstream and of higher status. Similar findings about the experience of general practitioners in comparison to hospital doctors were also presented by Pereira Gray (1984) and Waters and Wall (2007). Given this existing literature on multiple communities, this thesis adopts the view that medicine may be made up of a variety of communities of practice and explores whether the medical specialty in which a participant is located may impact on how they engage with an educational community.

Limitations of Communities of Practice

Whilst the theory of communities of practice has proved useful in a range of medical education contexts, there are several limitations to this theory. These limitations are

important to acknowledge in order that they can be considered and addressed within the context of this research.

In the original presentation of communities of practice one of the criticisms was that the theory did not take account of issues of power and hierarchy relevant to the participants' professional practice (Contu and Willmott, 2003; Kerno, 2008; Roberts, 2006). This is a key omission in terms of the hierarchical nature of medicine in particular (Cruess et al, 2017) as medicine consists of teams that have hierarchical structures rather than flat or collaborative ones (Bleakley et al, 2011). This hierarchy is evident in many ways, for example doctors who are very well qualified or who have been qualified for some time are referred to as '*junior doctors*' if they have yet to reach the level of consultant (Baddeley, 2017). Issues of power and status, related to this hierarchical structure, are particularly visible within medicine where women and other minority groups have often had difficulty in participating in a community of practice (Cruess et al, 2017).

A further criticism of the theory is that some of the concepts are considered to be '*slippery and elusive*' (Barton and Tustig, 2005 p.6). Indeed, there are multiple ways in which these ideas have been interpreted and applied, making comparisons between contexts difficult. Indeed, even deciding on the limits of a community can be difficult. As Gee (2005) argues,

'...we face vexatious issues over which people are in and which are out of the group, how far they are in or out when they are in or out. If we start with the notion of 'community' we cannot go any further until we have defined who is in and who is not, since otherwise we cannot identify the community.'

(p.215).

Therefore a focus on the spaces that people inhabit rather than membership of a community may be more helpful as there are different ways in which an individual may be a member of a community.

Application of the theory and comparisons between contexts can be further hampered by the fact that some cultures are pre-disposed to working within communities of practice, for example those more orientated towards individualism rather than collectivism (Kerno, 2008; Roberts, 2006). Furthermore, application of this theory has often been done in a wholly positive way (Kerno, 2008). Gee (2005) suggests that the concept of a community of practice conjures up ideas of members feeling a sense of belonging and connection with each other which may not be the case in places of work. This lack of belongingness, may be

particularly prevalent in communities where there are hierarchical rather than flat structures.

Despite these limitations, the theory of Communities of Practice provides a useful starting point to consider the development of medical educators' identities in this context.

However, it is important to bear in mind these limitations and thus I will be adopting a critical approach when drawing upon this theory.

Summary

As can be seen from the previous literature there are convincing arguments to focus on professional identity development of medical educators. Communities of practice provides a useful theory to frame this discussion and subsequent research for a variety of reasons. The social constructivist view helps to take account of the fluid nature of identity as well as the idea of multi-membership. Previous work has considered how medicine is a community of practice and therefore it is useful to build on this idea and consider education as a community of practice and the brokering that takes place between the two. Wenger's later work which considers learning and practice across landscapes may be useful in considering the complex nature of medical educators' identity development across a range of communities of practice.

2.6 Medical Education, Prestige and the Hidden Curriculum

As outlined in the section 2.5, one of the key criticisms of the theory of communities of practice as applied to medical education is the lack of acknowledgement of the impact of power on how individuals may engage with, and across, communities. This section explores the relative status of medical education as a discipline, the impact of the prestige economy (Blackmore and Kandiko, 2011) and the how the hidden curriculum (Hafferty and Franks, 1994; Hafferty and O'Donnell, 2014; Hafler et al, 2011) may transmit messages about the value placed on education, all of which may impact on medical educators' identity development and their practice as a broker.

Previous literature has reported on how medical education has been perceived to have a lower status than other activities that medics may be involved in, such as research or clinical practice. For example, teaching may be viewed as a secondary activity to clinical practice with a lack of extrinsic rewards and motivators (Hays, 2006) and whilst there is a requirement for all doctors to be involved in education and teaching, few have dedicated time for it (Budden et al, 2017; de Cossart and Fish, 2005). Historically, Klingensmith et al

(2006) argue, it is the clinician scientist rather than the clinician educator who has been favoured when it comes to academic promotions. They suggest that due to competing demands, educational scholarship is often regarded as optional. One reason for the optional nature of medical education research is the lack of research funding resulting in a lack of evidence base for making decisions about curricular and assessments (Archer et al, 2015). Despite being a '*vibrant community*' (van de Vleuten, 2014, p.761), Archer et al argue that medical education is viewed as an ugly duckling in comparison to other medical specialisms. Medical education journals generally have lower impact factors than medical ones, and the pool of research funding for educational research is less (Archer et al, 2015).

Drawing upon concepts from Bourdieu's theory (Bourdieu, 1997; Bourdieu and Wacquant, 1992), within this '*field*' of research funding, medical education is unable to secure as much economic '*capital*'. Capital can also take other forms beyond just economic, including symbolic (status and reputation) and cultural (types of knowledge). However, these types of capital are linked; for example, increased economic capital leads to, or may be the result of, increased symbolic power (Brosnan, 2010). A further reason for this disparity between medicine and education may be that teaching as an occupation does not have the same professional status as medicine. Winch (2004) argues that this is because the knowledge base of teaching is grounded in practice, whilst in contrast medicine has a scientific and objective body of knowledge and consequently is viewed as more prestigious.

The concept of the prestige economy (Blackmore and Kandiko, 2011) may prove a useful tool to analyse this relative status of medical education as a discipline. The prestige economy is described as a mechanism of exchange that exists outside of financial systems of exchange. Given that many activities that academics are engaged with have no explicit or direct financial gain, the prestige economy has been used to explain motivation to engage with these activities as well as identity development of an academic within a discipline area. For example, by editing a journal an individual may not gain any financial remuneration but is likely to gain status and credibility amongst their peers. However, the activities that make up the prestige economy may well vary from discipline to discipline as the discipline espouses its values through the work that it accepts as credible. Therefore, this has implications for individuals who are working across different disciplines which have different shared practices and epistemologies. For example, this may influence how doctors view a colleague who takes on a specific educational role such as leadership within a medical school. As was found in my IFS, this was a challenge for surgeons whereby they

were aiming to negotiate two different prestige economies where education was viewed as having a less prestige than research or clinical practice. As one participant stated *'education...has a tag of people pick up education who can't pick up anything else'*, whilst another commented that the belief that *'those who can, do and those who can't teach'* persisted within surgery.

One way in which doctors learn about the prestige economy and value of teaching and education is through the implicit cultural norms of an organisation, referred to as the hidden curriculum (Hafferty and Franks, 1994; Hafferty and O'Donnell, 2014; Hafler et al, 2011). The hidden curriculum is argued to have impact in medical education where students and professionals spend much of their time within the workplace culture. For example, Cope et al (2016) describe how the hidden curriculum impacts on the development of surgeons and their identity, stating that,

'Professional identity construction, which is multifaceted, complex process, constitutes a navigation of the hidden curriculum for postgraduate surgical learners, as norm attitudes and values for surgeons have not previously been explicitly articulated.'

(p.1)

From this quote, two points are potentially relevant to the construction of medical educators' identity. Firstly, have the norm attitudes and values been explicitly articulated for medical educators? As previously discussed, various policies state that doctors need to be involved in education, and organisations such as the Higher Education Academy and Academy of Medical Educators have published sets of standards that they require teachers in higher education and medical educators respectively to meet. However, how these policies are enacted may be dependent on local context. Do medical educators deliberately adopt these standards in their professional practice, or do they retrofit their practice to the standards when they are applying for recognition or accreditation from one of these organisations. Secondly, what does the hidden curriculum say about medical educators? Identities are constructed within organisations and therefore it is important to understand the structures and hierarchies that impact on identity formation (Monrouxe, 2010). From early on in their medical degree students are receiving and internalising messages about the value of teaching and education which they are then likely to reproduce in their own teaching roles. From my own experience, students often value objective knowledge which can be delivered didactically because this is the type of knowledge that they are most required to use in high stake examinations. Therefore, medical students learn from an early stage the type of teaching and knowledge that is most prestigious through the assessment

system that a medical school implements. Further examples from my own practice include the Professor of Medical Education who when introducing themselves at a conference referred to medical education as '*the dark side*' having originally worked in a medical discipline, or the post-doctoral researcher who wanted to take on a teaching fellow post but was deemed '*too good for teaching*' by their head of department. These small but reasonably frequent incidences build a picture of how education is viewed by some within the medical profession.

Summary

The concepts of the prestige economy and hidden curriculum can be helpful in considering the relative status of education within the medical profession. This may explain why the practice of brokering between communities is particularly complex in this context. In order to explore this complexity further, the next section discusses the issue of gender in medical education and how this may be a useful lens through which to illuminate the complexity and tension that medical educators may experience in terms of their own professional identity development.

2.7 Gender and Medical Education

The previous sections have discussed how the theory of communities of practice may prove a useful conceptual framework in considering the complexity of medical educators' identity and how the practice of brokering may be further complicated by the relative status of medicine and education. This section explores the issue of gender in medical education as one way of illustrating issues of power and hierarchy that, it is argued, are overlooked in Wenger's work (Contu and Wilmott, 2003; Kerno, 2008; Roberts, 2006) and that add to the complexity of professional identity development in medical education.

This section firstly outlines the rationale for using gender as a lens through which to explore the issues around power and status that medical educators may experience in their identity development. Secondly, changes in the number of male and female doctors will be reviewed in order to provide some context for this lens, as well as gender differences in teaching roles and teaching methods. Finally, ways in which individuals may manage tensions experienced as a result of these gender differences are explored.

Gender as a lens through which to consider medical educators' identity

Whilst identity is made up of many different features such as gender, ethnicity and social class, in the context of this thesis, gender may be most pertinent to consider in further depth for several reasons. There have been changes in recent years in the proportion of male and female doctors, as well as the gendered make up of some medical specialities. Since the early 1970s there has been an increase in the number of females entering medical schools and qualifying as doctors (Riska, 2009). Despite these changes in demographics, Tsouroufli (2016) refers to medicine being a '*gender neutral profession*' (p.3) in which gender should not impact on doctors' professional practice. Furthermore, Verdonk et al (2007) argue that generally '*doctors and teachers are hardly aware of the impact of gender on professional education*' (p.12), although where there is awareness, this is reported to be greater amongst female faculty than male (Risberg, 2004). A further reason for the use of this lens is the gendered nature of roles within higher education and the different approaches to teaching that males and females are more likely to adopt (Deem, 2003).

MacLeod and Frank (2012) also argue that adopting a critical approach, which is one that involves considering dominant discourses and unchallenged assumptions, remains absent from much of the medical education literature. They go on to suggest that medicine is complex and therefore a '*social science gaze*' can be useful in challenging '*the simple purveyance of biomedical and clinical knowledge*' (p.12). I would argue that medical education is also complex and therefore adopting a critical approach to some of the assumptions that are held about medical education is a useful step in challenging these assumptions and the associated dominant discourses. Furthermore, whilst Wenger's theory of communities of practice provides a useful framework through which to consider the experiences of medical educators, it is argued that the theory is largely blind to issues of gender (Paechter, 2003b). Also absent, as previously discussed, is acknowledgement of the role of power and hierarchy within communities of practice (Contu and Wilmott, 2003; Kerno, 2008; Roberts, 2006) and it may well be along gender lines that the impact of these power differentials manifest.

For these reasons, considering the gendered nature of the role and identity of these medical educators is important. However, clearly a limitation of focusing on issues of gender is the risk of ignoring age, ethnicity, nationality, and so on, and how these characteristics intersect with one another. It may well be that age and/or ethnicity play a

part in the development of medical educators' identity. For example, the experiences of medical students and doctors from black and minority ethnic backgrounds have been the focus for much research (e.g. Seabrook, 2004a) and there are calls to focus on intersectionality within medical education (Tsouroufli et al, 2011). However, the nature and scope of this thesis means that it is not possible consider all factors that may impact on an individual's professional identity development and therefore gender will be used as one example to illuminate the complexity of medical educators' role and identity.

Approach to considering gender issues

Before discussing the gender differences within the medical education, as well as higher education teaching more broadly, I will outline my approach to considering the issues of gender within this thesis. Many authors have problematized the concept of gender and I acknowledge the multiplicity of the terms '*gender*', '*female*', '*male*', '*femininity*', and '*masculinity*'. Postmodern and post structuralist feminists for example, argue that masculinity and femininity have no prefixed definitions (Freedman, 2001). However, whilst Paechter (2003a) acknowledges that the terms masculine and feminine are multiple and fluid, she also concedes that it is difficult to find more appropriate terms than '*gender*', '*male*' and '*female*' (Paechter, 2006) and the term gender remains useful in separating social constructs of male and female from biological ones (Freedman, 2001, Pilcher and Whelehan, 2004). Therefore, I am using the terms '*gender*', '*male*' and '*female*' in both this thesis and when interviewing participants to explore these ideas, primarily because these terms would be meaningful to the participants, rather than using the ideas of multiple and shifting masculinities and femininities.

Changes in gender demographics within medicine

As previously discussed one reason to focus on gender has been the changes in male and female demographics within the medical profession. Although medicine is unlikely to be considered a gendered occupation according to the Kanter's (1977) definition¹, the number of females entering the medical profession is increasing. This section will therefore provide an overview of the changing gender demographics in medicine, including specialty choice at postgraduate level.

¹ Kanter (1977) defines a gendered occupation as one where 85% or more of employees are either male or female.

According to Riska (2009) females currently make up between 40 and 70 per cent of first year medical students in western countries, whilst Carvajal (2011) reported that 54% of physicians in the UK under the age of 35 years were female, with similar figures found in other European countries. By 2017, females will make up the majority of all doctors (Bleakley, 2013). This '*feminization of medicine*' (p.91), Riska (2009) argues, has resulted in a number of predictions. One is that female physicians will bring a more holistic and empathetic approach to medicine and an increased focus on women's issues. Bleakley (2013) suggests that female doctors tend to have different communication styles, which are often perceived by patients as being better than male doctors. According to Cassell (1997) further differences include male doctors being

'more independent, detached and hierarchical', whilst female doctors 'tend to be more nurturing, caring and co-operative.'

(p.47).

A female surgeon in Kinder's study (1985) suggested that these qualities and the way in which female surgeons interacted with patients, colleagues and students, would improve the way in which surgery was practiced and taught. Differences are also seen in medical students where female medical students appear to be more care orientated than their male counterparts (Verdonk et al, 2007). As the number of female doctors increases and they take on more senior roles, more female type attributes and values, such as communication and teamwork are likely to be more acceptable within the profession (Seabrook, 2004b).

However, unrealistic expectations about the changes that female doctors can bring about present them as a homogenous group and puts too much pressure on them to be the '*vanguard of holistic medicine*' (Riska, 2009, p.92). Those who take a more pessimistic view argue that this gender equality in terms of the number of male and female doctors may actually be seen, not as females entering a high-status profession, but that the risk is that medicine becomes viewed as low status '*women's work*' and subsequently, males are put off applying to medical school (Riska, 2009).

Gender differences in medical specialties

Despite this increase in the overall number of females in medicine there continues to be differences in the number of males and females within different medical specialties (Riska, 2009). For example, female doctors are more likely to work part time and choose

specialities such as paediatrics and primary care, whilst less likely to choose specialities such as surgery and anaesthetics (Bleakley, 2013). One possible reason for this is the differing styles of behaviour within different specialties with a more male style of behaviour being more common in specialties such as surgery (Baxter et al, 1996). Participants in Svirko et al's study (2013) reported that they thought both gender and ethnicity impacted on career prospects within medicine. For example, the majority reported that some specialties such as general medicine were dominated by males, whilst others such as paediatrics and palliative medicine were more suited to females. There was also a perception amongst both female medical students, as well as those from minority ethnic backgrounds, that they would have to do better than other students to progress in their careers (Seabrook, 2004a).

As well as gender differences in clinical specialties, there are reported differences in academic medicine (Kuhlman et al, 2017; Morton et al, 2008; Westring et al, 2016), particularly at senior levels, with only one in 10 clinical professors being female (Sandhu, Margerison and Holdcroft, 2007). However, these figures are not unique to medicine and are reflected across academia globally at both middle (Kuhlmann et al, 2017) and senior levels (Coate and Kandiko Howson, 2016; Savigny, 2014).

As well as differences in specialty choice and academic medicine, some research suggests that medical students have gendered learning experiences. For example, female students reportedly have fewer opportunities in clinical practice generally (Kilminster et al, 2007) and male students have reportedly experienced an '*anti-male*' environment and have fewer opportunities for clinical practice in obstetrics and gynaecology attachments specifically (Burgo and Josephson, 2014; Higham and Steer, 2004).

These findings from research with both qualified doctors as well as medical students suggests that, whilst there is an increase in the number of females joining the medical profession, gender differences still exist within the make-up of different specialties (Riska, 2009) as well as in the learning experiences of students.

Reasons for gender differences in specialty choice and experience

Riska (2009) suggests that, from a sociological perspective there are three main explanations for these differences in choices. Firstly, that gender socialization leads to expectations about the skills and behaviours of males and females, and that females often cite issues such as working hours etc. as important in their choice of specialty. Cassell

suggested that several her observations about female surgeons could be viewed through the lens of gender being a socio-cultural construction. Gender differences are socio-cultural constructions and reinforced through the hidden curriculum. Secondly, it is suggested that there are organizational barriers which prevent females from accessing particular medical specialities. Park et al (2005) suggest that both real and perceived barriers exist that may deter female students from pursuing surgery. Real barriers may include the lack of role models as well as sex discrimination. For example, Baxter et al's study (1996) found that a lack of female role models in surgery deterred female students from pursuing surgery. Perceived barriers are more likely to include issues around work life balance and family which are different from the way in which female surgeons perceive these issues. Finally, it is argued by Sandhu et al (2007) that '*embedded values in medicine and healthcare*' are male dominated, with males controlling '*the knowledge and power of the profession*' (p.100), which in turn will result in gender differences in specialty choice.

Gender differences in approaches to teaching and education

Having considered gender differences within the medical profession, I will now turn attention to considering gender differences within higher education. Deem (2003) argues that taken as a whole, working in academia is unusual in comparison to other job sectors in that,

'ostensibly women and men academics do the same job involving teaching, research and administration.'

(p.243)

However, when looking at different types of academic institution and different disciplines, gender differences appear to be more common place. For example, some disciplines such as science are more heavily reliant on research and laboratory based work which is arguably less flexible than desk based research which is more common place within the arts and social sciences. Lack of flexibility is more likely to impact on females due to their increased family responsibilities. Furthermore, in several studies reported by Deem, males appeared to rate research more highly than females. The nature of the organisational hierarchy also impacts on the career progression of females with those organisations that have a more traditional and hierarchical structure having fewer opportunities for females to progress within leadership and management.

There are also reported differences in how male and female educators approach their role and practice. As Sargent (2005) argues '*work itself is typically imbued with gender meanings*

and defined in gendered terms' (p.251). In the context of higher education teaching this includes the teaching methods used as well as how knowledge is shared and created with students. Overall, female academics in higher education are more likely to be involved in teaching rather than research than their male colleagues and more likely to take on pastoral roles and responsibility for students' welfare (Becher and Trowler, 2001). These differences tend to be more marked in disciplines that are male dominated (Dominelli, 1998) and are often linked to the status of these activities, which will be discussed in more detail later in this section. However, in relation to medical education, it has been found that there are no differences in the quantity of teaching carried out by female and male junior doctors (Prichard et al, 2011).

In terms of specific teaching methods, Bress (2000) argues that *'lecturing is a demonstration of expertise and status'* (p.4), with males learning this from role models and therefore being more comfortable with this teaching method. *'Teaching by humiliation'* (Spencer, 2003, p.591), a strategy experienced by many medical students, has also been found to be more common amongst male teachers than female. Cassell (1997) found that female surgeons were not permitted by other surgeons to teach by humiliation because this is not congruent with their gender. By observing teaching by humiliation, it is likely that students learn about hierarchy in medicine as well as competition rather than collaboration, and associate these more with male medical educators than female (Lempp and Seale, 2004). In contrast, feminist pedagogy is characterised by the *'democratic creation of knowledge'* (Macleod and Frank, 2012, p.12). This includes approaches which place a greater degree of responsibility for the learning on the learners and focus on the *'inequitable social relations and the learners power, privilege and status'* (p.12). MacLeod and Frank argue that feminist pedagogies are in many ways aligned with medical education approaches because of the emphasis within medicine on self-directed and lifelong learning. However, there are other key methods in medicine such as the reliance on traditional didactic lectures and examples of teaching by humiliation which run counter to this view, highlighting, and in some cases exploiting, the power differential between students and teachers.

Gender and the status of teaching in medicine

As has been previously explored, there are some links between gender and issues of status and hierarchy within a discipline. Baker et al (2011) define status as *'the ability or capacity to act or to exercise influence'* (p.98) and has many dimensions, of which gender is one.

Although referring to compulsory education, Drudy (2008) argues that the increase in the number of females joining the profession has led to a decrease in the status of the teaching profession and the same may be applicable within higher education. Within academia, females are more likely to work in lower status universities, often because these universities are more teaching focused which provides greater flexibility for females who often have increased family responsibilities. They are also more often initially appointed at a lower rank and are promoted more slowly (Deem, 2003). There are also fewer females appointed at professorial level, particularly in hard applied subjects such as medicine (Becher and Trowler, 2001)². Furthermore, there is evidence to suggest that females are more likely to take on lower status and lower paid roles within academia that are reflective of some of the gender differences within society more widely. For example, in Coate and Kandiko-Howson's (2016) study on gender and prestige within academia, they reported that female academics tended to engage in more teaching (a less prestigious activity) than their male colleagues. They also reported that females tended to undertake fewer prestigious activities such as being the editor of an academic journal and that these factors combined resulted in females being disadvantaged. As one of their female participants reported,

'There is a prevailing attitude, although I accept not a deliberate one, that women are the worker bees and men the shining academic stars. The work that women do in this university needs to be recognised.'

(p.579)

This is analogous to the concept of domestic labour to explain the fact that female academics are more likely to engage with administrative and organisational tasks related to teaching (Morley, 2003).

Managing identity

As a result of the interplay between gender and status, individuals may experience tensions in managing their identity. For example, if they feel they need to adopt particular roles within medical education or approaches to teaching because of socialization and/or real and perceived barriers. Two ways in which individuals may manage their professional

² Becher and Trowler (2001) distinguish between soft pure subject such as English Literature, soft applied subjects such as social science, hard pure subjects such as physics and hard applied such as medicine.

identity in relation to status and prestige is through identity capital (Cote and Levine, 2002) and impression management (Goffman, 1959). These will be briefly discussed in turn.

In his analysis of medical student identity formation, Goldie (2012) suggests that the ability of individual, in this case medical students, to defend their identity is dependent on the amount of identity capital that they hold. Identity capital is made up of tangible factors such as an individual's gender, social class or membership of particular groups or organisations, whereas intangible factors may include levels of self-esteem, critical thinking skills and an internal locus of control. Goldie argues that intangible factors may offset an individual's lack of tangible factors. For example, a female working in a male dominated environment may be able to defend her identity formation through high self-esteem or a strong sense of purpose. In the case of medical education, a tangible factor, such as the relatively low status of medical education in some contexts, may be mitigated if the individual has high self-esteem or a clear sense of purpose regarding their educational role and identity. A second strategy is impression management (Goffman, 1959) whereby an individual deliberately behaves in ways to control how others may perceive them. For example, Mattsson (2015) argues that females in academia may act in a particularly feminine way to mitigate against being viewed as too successful or intellectual.

Summary

Given the changing context of medicine regarding the number of females in medicine as well as the previous research on gendered practices within higher education and the relationships between gender and status, it seems pertinent to explore medical educators' identity development through the lens of gender

This section has outlined the increase in the number of females entering the medical profession as well as gender differences within specific medical specialties. Reasons for these differences include socialisation, lack of role models and barriers such as work-life balance. Gender differences in approaches to teaching and education are also considered with differences between male and females academics occurring in the amount of teaching they undertake as well as the type, for example lecturing or personal tutoring. Links between gender and status of activities are also outlined with some consideration to how individuals may manage these tensions, for example through impression management or drawing upon identity capital.

2.8 Conclusion

This section has considered the current literature on how medical educators are defined as well as current practices related to the professionalisation and development of these individuals. Currently there are a range of views about who should be considered a medical educator and how doctors should best develop their teaching practice. There is some evidence from both within medical education as well as higher education more broadly to suggest that postgraduate qualifications in education are of benefit to both educators and learners. However, there continues to be a lack of clear route for those wishing to pursue a career in medical education.

The existing literature on communities of practice is plentiful, particularly within medical education. A key feature of Wenger's theory is the idea that, whilst full of potential, the role of broker is complex and challenging. Medical educators who have completed a Master's in Education are likely to find themselves in this brokering position, having to practice across the two communities of medicine and education.

A key limitation of Wenger's theory is the lack of acknowledgement about the influence of power and hierarchy which are prevalent within medicine. Both the hidden curriculum and the prestige economy are powerful influences on the socialisation of medical educators and practices that are valued. Furthermore, the profession of medicine is changing in terms of the number of females joining the profession, yet there remain significant gender differences in terms of the nature of the educational role that male and female doctors take on.

Having considered the previous literature, the aim of this thesis is to explore the ways in which doctors from different specialties who are graduates of, or are near completion of a Master's in Education course, develop and negotiate their professional identity. Specifically, the research questions for this work are

1. How do medics develop their medical education identity and what may be the similarities and differences between different groups of medics (surgeons, psychiatrists, physicians, general practitioners etc.) in this respect?
2. How do different participants (reflecting a range of specialties) broker their identity between the different communities of practice of medicine and education?
3. Based on these experiences and comparisons, what factors appear to be influential on the shaping of professional identity of medical educators?

METHODOLOGY AND METHODS

3.1 Introduction

A qualitative and social constructivist approach was adopted for this piece of research. 15 one to one, semi structured interviews were conducted with participants who were all medically qualified and had completed or were near completion of a Master's in Education or related sub discipline such as medical, surgical or clinical education (for brevity and simplicity referred to from here on as Master's in Education). Participants were recruited to the study via both volunteer and snowballing sampling, with initial recruitment emails being sent to graduates and final year students of three Master's in Education courses that I had previously or currently taught on. For the programme where I had a current teaching commitment, only graduate students were recruited to minimise any issues of power and coercion. Each interview was audio recorded, transcribed and then returned to the participant for verification and to make any edits or amendments that they wished. Analysis of the interview transcripts took the form of thematic analysis with each transcript being coded and themed. I chose to take an iterative approach, analysing interviews as I went, in order that this might influence the development of subsequent interviews.

In addition to conducting semi structured interviews, I also undertook a review of the websites of a range of medical professional bodies as well as three medical journals. The aim of this orientation exercise was to explore differing communities of practice within medicine and how they might perceive education, in order to provide some detail about the backdrop against which medical educators develop their identities.

The aim and purpose of this chapter is to describe and discuss these design decisions in more depth, with reference to the relevant literature on qualitative research methods and methodology. Specifically, I will discuss the methodological approach chosen for this piece of research and how this informed the data collection methods used. In doing so, I will explore my own underlying assumptions about the nature of the research and outline my attempts to remain reflexive as a researcher. I will also present practical aspects of the research such as how participants were recruited to the study and how ethical issues were addressed and minimised.

3.2 Methodological Approach

A qualitative research perspective was appropriate for this research project for several reasons. Ng et al (2014) argue that qualitative researchers are interested in ‘*how*’ and ‘*what*’ questions around social phenomena and the experiences and perceptions of groups or individuals. Furthermore, Bryman (1988) characterises qualitative research as seeing the issue or topic through the perspective of the participants, rather than how the researcher has conceptualised the topic. For the purposes of this study I am asking **how** participants develop their professional identity and am interested in their experiences and how social factors, such as relationships with colleagues, impact on the development of their professional identity. I am aware, both from the literature and my own experience, that development of professional identity is complex and therefore qualitative methods are best placed to try and capture some of this complexity (Higgs and Cherry, 2009)

Within qualitative methodologies there are a range of philosophical perspectives that can be drawn upon (Savin-Baden and Howell Major, 2013). The approach adopted for this research is a weak social constructivist approach. That is, an approach that acknowledges that knowledge and meaning are socially constructed through interacting with others (Savin-Baden and Howell Major, 2013) and that multiple realities may co-exist (Illing, 2014). Furthermore, as Cantillon (2016) argues, the social constructivist perspective

‘holds that valid interpretations can be reached by researcher’s reflexive engagement with (textual) data.’

(p.995).

I am adopting a weak social constructivist approach because I am not assuming that there are no facts of matter, but only that people’s experiences shape the world in different ways and from different perspectives. In addition to this weak social constructivist perspective, I also drew upon elements from critical social theory, an approach justified by Savin-Baden and Howell Major (2013) who argue that philosophical approaches should not be viewed in isolation and can borrow elements from each other. Critical social theory adopts an approach interested in power structures and how these may be challenged in order to *‘transform the lives of those oppressed by these structure’* (Savin-Baden and Howell Major, 2013, p.23). As discussed in the literature review, I am interested in how the relative status of education and the issues related to gender impact on participants’ identity and practice. Therefore, in drawing upon this paradigm, there is acceptance that certain things should be different and that experiences are not just a matter of differing perspectives.

Adopting such approaches impact on the chosen data collection methods as well as how the data analysed. One such implication of this type of approach is, as Illing argues, that,

'the researcher cannot and should not be separated from the research participants and hence the research outcomes are a joint construction of the research process.'

(p.336).

Similarly, Barbour (2014) refers to the idea of generating data rather than the commonly used description of collecting data, whilst Lankshear and Knobel (2004) argue that data is not *'out there'* (p.172) waiting to be collected, rather it is constructed during the research process. As will be described in further detail later in this chapter, this approach impacted on the way in which I conducted the interviews with the participants and how I went about analysing the data.

3.3 Setting and Context

Bryman (1988) argues that it is important to acknowledge and understand phenomena within their context, what is referred to as *'contextualism'* (p.61). As outlined in the introduction, all doctors are involved in the teaching and training of medical students, trainee doctors and colleagues. However, the range and nature of this educational involvement varies considerably between individuals. Furthermore, there are a wide range of people who are involved in the education of medical students and trainee doctors and not all are medically qualified themselves e.g. nurses, physiotherapists, scientists, educationalists etc. However, for the purpose of this research I was interested in those who were medically qualified whether they currently had a clinical role or not. This was because I was interested in how the professional identity of a doctor intersected or not with that of the educator and how these two aspects of an individual's professional role and identity co-existed.

I decided to use completion or near completion of a Master's in medical, surgical or clinical education or similar as indication of a particular level of commitment to education. There is some discussion both in the literature and elsewhere, such as social media sites, as to whether completing a Master's in education was necessary to define oneself as a medical educator. I do not necessarily view it as a requirement, but I wanted some commonality between participants in order that I could draw comparisons between and across the interviews. I also thought that completion of a Master's would have some impact on participants' identity, not least because it may distinguish themselves as separate or different in some way from peers and colleagues. As a course director of a Master's in

Education course, it was also of professional interest to more fully understand how medical educators saw themselves and how completing a Master's in Education may impact on this view.

Researcher positionality

In conducting this research, it was important that I acknowledged my own position in relation to the subject under focus, the participants and the context (Savin-Baden and Howell Major, 2013) and that I remained reflexive as a researcher. Barbour (2014) defines reflexivity as,

'the impact which the researcher has on the data elicited and the impact of the research process on the researcher.'

(p.109).

In drawing upon a social constructivist approach, it is therefore important that I was mindful of the influences that I would have on the research process. For example, I aimed to be explicit in my write up of the process of conducting the research and specifically the interviews, as well as the design decisions taken. I also kept a research diary (see appendix 1 for extracts) which enabled me to track my thinking, and reflect on the design decisions taken and the process of conducting the interviews.

Being reflexive also required acknowledgement of my own professional identity and context, as well as my relationship with participants and how these factors may have impacted on the generation of data (Green and Thorogood, 2014). My own background is within psychology and education, having worked for a number of years in both secondary and further education. Since 2009 I have worked within a medical education context firstly in an institution focused on postgraduate training and education of doctors and subsequently for the last 6 years at a medical school and therefore primarily focused on supporting those who teach in an undergraduate context. I am not medically qualified but have some understanding of the context within which medical practice including medical education takes place. As part of the initial recruitment email to potential participants, I stated that I was a doctoral student, but also my professional role as a Principal Teaching Fellow in Medical Education. Whilst I did not give any further details I wanted potential participants to be aware that I was familiar with a medical education context. Some of the participants knew me, either because they had been students on the MEd course that I am course lead for or through other professional networks. Therefore, a significant number were likely to be familiar with my own background and context. Some of the participants

with whom I was unfamiliar asked about my background, often towards the end of the interview and when using medical terms or abbreviations in order to check my familiarity and understanding of these. However, with the information provided on the participant information sheet I felt that participants could make some judgement about me and the value and credibility of my research.

There was also some degree of equity about the interaction that took place in the interview. By virtue of the fact that participants had completed a MEd course they would have been used to speaking to people like me and familiar with the process of educational research. Therefore, there were fewer power dynamics than in other pieces of educational research I have conducted, for example with medical students. However, the participants would have, no doubt, made assumptions about my own beliefs and values, partly through the title of the research and, for those who knew me, that fact that they knew me as a course lead for a Master's in Education. For example, one participant prefaced a comment about his own view of education by saying '*you're not going to like this...*'

As well as considering my own professional position, I also considered my own beliefs about the value of education in general and specifically completion of a Master's in Education by doctors and the subsequent benefits of this to them and their learners. For example, I believe that the professional development of medical educators through completion of a Master's in Education is generally positive and that faculty can learn to be more effective educators, rather than being a good teacher resulting from some inherent characteristics (MacDougall and Drummond, 2005). I also think that a Master's in Education should be a transformative experience and help MEd graduates to work across the disciplines of medicine and education.

Keeping a research diary as advocated by Burgess (1981) enabled me to interrogate these assumptions and to track my thinking during the research. The diary enabled me to reflect on the design decisions taken and any thoughts and reflections after each of the interviews. These notes then fed into future interviews both in terms of developing my technique, but also in terms of initial data analysis.

3.4 Recruitment and Negotiating Access

Potential participants were selected using both volunteer and snowball sampling (Savin-Baden and Howell Major, 2013). Programme leads for three Master's in Education were approached as gatekeepers to seek permission to contact graduates from their programme

through email via the course administrator. These were three Master's programmes with which I had some connection and I did this in order to prevent me from trying to sample from a very large pool of potential participants who would be difficult to access. I contacted the course leads via email, having thought carefully about how I, as a course lead, might feel about receiving such an email. Questions I thought they might consider included, was the researcher going to ask about my course?; Would the course be identifiable?; How might criticisms of the course be handled?; If I said yes to this researcher would I feel I had to say yes to other researchers who may ask for access? I therefore drafted an email outlining my research and reassuring the course leads that I would not be asking about their course specifically and that it would not be identifiable in any write up. The response from three course leads was very swift and straightforward. However, the extract below from my research diary, reveals some of the anxieties I had about asking others for help including those facilitating recruitment as well as the participants themselves.

'I have no appointments in my calendar and so decide to spend some time sorting out recruitment. I open the saved email to the course administrator and my finger hovers over the send button. I hesitate and open the attached participant information sheet double checking it for errors. It's ok I think. I hit send and turn my attention to another task. An email pops up. It's from the course administrator. 'Hi! I've sent out your email to our final year students.' She signs off 'Good luck! 😊'. I'm relieved – that was quick and seemed straightforward. Oh, but she's only sent it to final year students and not graduates. I hit reply. Might you be able to send it to your graduates as well?' I ask wondering if she can sense my anxiety. 'As long as it's not too much trouble of course'. I hit send knowing that agonising over the email won't help. Again she replies promptly – 'No problem! I just hadn't seen that bit in your email'. I'm relieved.

By mid-afternoon, four potential participants have contacted me. I feel a mixture of relief, gratitude and concern. I now need to sort out when and where to interview them, trying to navigate busy schedules (both theirs and mine). I'm not sure I will get these interviews done, if any, before my supervision meeting. However, I decide that a well-crafted response is preferable to a rushed one and therefore decide to follow up these emails after work.

On the bus on the way home I think about what motivates people to volunteer for my study. AC suggests that people like to talk about themselves. I think he's right and hope that they don't feel obligated in some way. I reassure myself that two of the participants don't even know me, and knowing the other two participants as I do, I think that they would both be capable of ignoring my recruitment email.'

Research diary extract – May 2016.

Whilst aiming to minimise coercion, a strength of this recruitment strategy was that these were courses that I had some connection with and therefore this helped with gaining access. A limitation was that I was only initially selecting from a small number of Master's

programmes which were UK based. However, this limitation was potentially overcome by using snowball sampling. Each participant recruited was asked to nominate one or two potential other participants who met the inclusion criteria of having completed a MEd in medical/clinical/surgical education for me to approach. This method was chosen because existing participants would perhaps be in a better position to identify participants who I was unaware of, or who had perhaps graduated from courses that I did not have access to (Cohen et al, 2011). Noy (2008) also argues that along with the practical benefits of snowball sampling this sampling technique can also reveal some characteristics about the group that is being sampled. As Babbie (2017) questions and then suggests,

‘do the people you are interviewing know others like themselves? Are they willing to identify those people to researchers? In this way, snowball sampling can be more than a simple technique for finding people to study. It in itself can be a revealing part of the inquiry.’

(P.197).

In both the participant information sheet and email that I sent when sending the interview transcript back to the participant for verification, I asked participants to nominate one or two people who fitted the recruitment criteria and who they thought would be interested in taking part in the research. In total, only two participants were recruited in this method. It is difficult to say why this number is not more. As Babbie suggests it may be that they do not know others like them and therefore are not able to nominate someone. As will be discussed in the results section, several the participants suggested that a lack of a network of medical educators resulted in them feeling isolated or finding that there were not sufficient numbers of people to build capacity within the medical education community. Therefore, this suggestion may well hold some truth. However, it may also be that they themselves were busy and therefore do not have time to contact me about other potential participants, or that they do not want to put pressure on colleagues to take part in the research by volunteering them to do so.

In all cases, participants were recruited on a first come first served basis and this was made clear on the participant information sheet.

3.5 Ethical Issues

Although this was a relatively low risk education research project, as with all research there were several ethical issues that needed to be considered and minimised. As a King's College, London student I was required to gain ethical approval from the low risk approval process at this institution. I also gained ethical approval from Imperial College, London

where I worked and had planned for some of the interviews to take place. At times, this felt an onerous task but I tried to follow the advice that I provide my own students which is to think about ethical approval as a way of making the research more robust and comprehensive. Once I took this view, the process of gaining ethical approval supported me in considering and finalising the plan for my research. In particular I had to decide how I would approach and recruit participants, and how I would engage participants in the process of snowball sampling, being mindful of ethical issues such as coercion.

Despite my project being deemed '*low risk*' by the King's College, London ethical approval process, I felt a particular concern to get the ethical approval process '*right*' and ensure that I had the right approvals in place. In October 2015 I had taken on a new role as the lead for medical education research in the Department of Primary Care at my institution. I was therefore involved in advising people about educational research and gaining appropriate ethical approval for projects. As part of my role as MEd course director, I was also involved in advising students about ethical issues regarding educational research, as well as acting as a reviewer for ethics applications. I therefore felt it was important in terms of these roles and my credibility that any research I did had been given the appropriate approvals and was conducted in an ethical way. This meant that negotiating what ethical approval I needed took some time and I wanted to be confident in the choices I had made. Ethical approval was granted by both institutions with only one minor amendment to the participant information sheet required. (See appendix 2 and 3 for confirmation of ethical approval).

All participants were required to provide informed consent to take part in the study. At the time of recruitment participants were provided with an information sheet detailing the research and what their participation would involve (see appendix 5). Prior to taking part in the research participants were then asked to read and sign a consent form (see appendix 6). Participants had the right to withdraw from the study along with withdrawing any data up to the point of data analysis and participants were informed of this on both the participant information sheet and consent form. Participants were assured that all data would be stored securely in accordance with King's College London guidelines and would only be accessed by myself and my supervisor. All transcribed data was anonymised with pseudonyms consistent with participants' gender and ethnicity being used. Furthermore, any identifiable information such as specific stage of training, which MEd course they had completed or geographical location was removed. The interview questions did not focus on

or specifically ask participants about sensitive issues. However, if participants raised sensitive issues then I was clear that these would be dealt with in the normal way such as referral to an appropriate person or my supervisor. I was also conscious of the amount of time participants would be giving up to take part in the study and therefore decided that interviews should last no more than 60 minutes, and in reality, most were approximately 45-60 minutes. I also offered participants the option of conducting the interview by telephone or to meet face to face at a location convenient to them, to better accommodate their schedules.

Power, coercion and fellow researcher collegiality

Given my position as a MEd course lead, I was particularly concerned about issues of power and coercion within this study. This was because I knew some of the potential participants and in some cases had taught or supervised them. Therefore, I asked course administrators to send emails on my behalf in order to minimise coercion that might be caused by an email that was sent directly from me. This meant that potential participants could perhaps more easily ignore the email and not feel coerced into volunteering for the study. I also only recruited graduates for the course that I was the current course lead for and therefore did not have any current involvement in teaching and/or assessing any of the participants. I also asked potential participants to contact me via my student email account rather than my work account, as one way to emphasise my student status and therefore minimise any power differential that might be perceived. However, I also thought that some personal contact might incentivise potential participants. I could imagine that unless potential participants had lots of availability, it may be difficult to give up time for and be interviewed by someone you did not know. Despite this assumption, I was pleasantly surprised by the response from participants that I did not know. I quickly sensed that there was interest in the project and a feeling of researcher collegiality, with one participant responding by saying – *‘I know from my own MSc research how difficult it is to get volunteers!’*

This sense of fellow researcher collegiality was also present in my earlier negotiations to gain access to participants. All the course leads are involved in supporting students in undertaking educational research as well as conducting their own research and therefore likely to be aware of some of the challenges of recruiting participants. This may have led them to be more open in allowing me access to their MEd students and graduates.

3.6 Interviews

Within this type of educational research, qualitative interviews are increasingly being used (Kvale and Brinkmann, 2009), with the semi structured, in depth interviews being the most common type that is utilised (DiCicco-Bloom and Crabtree, 2006). Reasons for this include the fact that many potential participants will be familiar with the concept of an interview as opposed to more novel data collection methods, such as audio diaries or reflective accounts (Savin-Baden and Howell Major, 2013). It is also a convenient way of gathering richer, more in-depth data than other methods such as questionnaires (Forsey, 2012; Savin-Baden and Howell Major, 2013). Whilst Barbour (2013) suggests that there is a wide variety of interview types and approaches, Edwards and Holland (2013) argue that all qualitative interviews have similar features. That is, they all involve interaction between an interviewer and an interviewee (or several interviewees) around a topic or theme. As will be discussed further, the interviewer has an idea about the topics or themes that they want to cover in the interview, but there is sufficient flexibility to take account of the interviewee's own views and experiences. Furthermore, those who use qualitative interviews adopt a perspective where, according to Edwards and Holland,

'knowledge as situation and contextual, requiring the research to ensure that relevant contexts are brought into focus so that the situated knowledge can be produced. Meanings and understandings are created in an interaction, which is effectively a co-production, involving the construction or reconstruction of knowledge.'

(p.3).

In illustrating this perspective, Kvale and Brinkmann (2009) position interviews as *'conversation as research'* (p.2) whereby knowledge is constructed as a result of the conversation between two people, the interviewer and interviewee. They propose two metaphors for the research interview; the mining metaphor and the travelling metaphor. In the mining metaphor the role of the interviewer is as a miner, extracting the information or knowledge from the participant and bringing it to the surface as uncontaminated as possible. In this type of interview, the data collection and analysis take place separately and is akin to more positivist and scientific methods. The second metaphor is one of interviewer as traveller and is more akin to the original Latin meaning of conversation – *'wandering together with'* (p.49). Here the data collection and analysis are intertwined and is a method more similar to research in anthropology. During my interviews I attempted to adopt the second of Kvale and Brinkmann's metaphors by being conscious of how the data was being

constructed between both myself and the interviewee. This approach to interviewing was also more aligned with a constructivist methodology.

One to one interviews were selected as the main data collection method for several reasons. One advantage is that the interview provides the participant with more freedom to discuss the issues that are of importance to them. Measor (1985) refers to this as 'rambling' and suggests that this is an important feature of the interview. Despite the interviewer yielding some control to the interviewee and having to remember to move backwards and forwards through the interview schedule, the 'rambling' allows the interviewee to discuss those issues which are of relevance and significance to them. This will reveal what is important about the topic which will be of interest. Mason (2002) presents further advantages of using qualitative interviews, arguing that by using this data collection method researchers are able to explore,

'the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants; the ways that how social process, institution, discourses or relationships work, and the significance of the meanings they generate.'

(p.1)

Of relevance to this study were the social processes that impacted on participants' professional identity development, for example how participants interacted with colleagues, their relationships with others, and their role and position within an organisation. The use of one to one interviews enabled these factors to be explored in depth.

Other data collection methods were carefully considered but excluded for several reasons. Use of questionnaires would be too limited with little or no opportunity for participants to expand on their answers or for me as the interviewer to probe for clarification or seek illustrative examples. I had also had previous experience of using an online survey to research aspects of students' development following a Master's course and this had not proved particularly fruitful either in terms of the response rate or the depth of responses provided. The use of focus groups was also considered as it is perhaps a more time efficient method of data collection for the researcher and there are benefits of interesting and useful data being generated between participants (Lindlof and Taylor, 2002). However, I felt that as I was researching professionals they may be less willing to discuss aspects of their development, perhaps difficult aspects, with other professionals who they did not know. Although interested in what similarities there may be in participants' experiences, in

the initial data collection phase I was interested in each individual's story and experiences (Savin-Baden and Howell Major, 2013). There was also the practical aspect of getting a group of busy professionals together at one time and in one location for a focus group which would prove challenging (Savin-Baden and Howell Major, 2013). One to one interviews, possibly via Skype or phone would therefore be considered to be easier in terms of participants' other commitments. I was also interested in the depth of response from participants and this would perhaps be difficult to probe and access in a time limited focus group with several participants.

As with all data collection methods, the use of interviews has limitations which I endeavoured to acknowledge and minimise. Firstly, as Anderson (2010) suggests, interviews are heavily dependent on the skill of the individual interviewer. As discussed in the subsequent section about how I developed my interview technique, as a novice researcher I was acutely aware that the initial interviews were not as in depth, probing or fluid as later ones. I aimed to address this by reflecting on each interview and identifying areas for further improvement on my part as the interviewer. Secondly, Anderson also suggests that issues of anonymity and confidentiality are heightened in an interview, as opposed to say an anonymous questionnaire. To try and minimise these issues, I assured participants of anonymity and confidentiality, although outlined situations where I might need to break confidentiality. As previously described, each participant was provided with a pseudonym and I removed any references to their job role, where they worked or other characteristics that might make them identifiable. Finally, Forsey (2012) argues that interviews are unreliable because participants' recollections may be incomplete or they may be engaged in impression management. Again, I tried to minimise this risk by assuring participants of anonymity and confidentiality, and by asking broad and open-ended questions.

Regarding the number of interviews conducted, I considered Edwards and Holland's (2013) view about the factors influencing the appropriate number of interviews for any given project. They suggest considering epistemological and methodological issues, such as the number of interviews needed to '*build a convincing narrative based in rich detail and complexity*' (p.66). In terms of practicalities, issues such as time, funding and the level of degree, should be factored in. Therefore, for this thesis issues such as being a lone researcher, completing a doctorate part time, and having very little funding were all factors when deciding on the number of interviews to be conducted. Finally, they suggest taking

account of what will be acceptable to the academic community in which the research is located. Green and Thorogood (2014) offer similar advice suggesting that if a researcher is looking to address specific research questions then more than 15 interviews would be unlikely to yield new themes where the participants are from a reasonably homogenous group. Therefore, taking into account the above points, and after discussion with my supervisor, 15 interviews seemed an appropriate number.

As is a common feature of qualitative interviews, I created an interview schedule or guide, rather than having a strict set of questions to ask each participant (see appendix 7).

Edwards and Holland (2013) suggest that the advantage of having an interview guide is that the interviewer is able to,

'pursue topical trajectories that may stray from the guide when she or he feels this is fruitful and appropriate.'

(p.54).

In beginning to create the interview schedule, I followed Luker's example (2008) of writing questions on separate pieces of paper (one per piece) using everyday language. I then grouped these questions together and considered how they may be ordered in a natural conversation. As suggested by Spradley (1979), I included a range of different question types, beginning with broad open questions, and ensuring that I included verification questions and comparison questions, for example asking participants to compare their experience with colleagues who perhaps also had completed or had not completed a Master's in Education. Forsey (2012) recommends beginning the interview by asking the participant to say a little about themselves. This helps to provide context for their subsequent responses. Therefore, I began each interview by asking participants to say a bit about their professional role and the educational activities that they were involved in.

Arranging each interview took some time, with back and forth correspondence with each participant normally via email to agree a suitable date, time and location. During this correspondence I resent the participant information sheet and explained that each participant would be given a pseudonym in the final write up to provide anonymity. Following on from de St Croix's (2015) strategy for naming participants in her PhD thesis on volunteer youth workers, I asked participants to choose a pseudonym if they wanted. As well as a practical outcome of participants being able to identify themselves in the final write up of this thesis, it also gave participants the opportunity to have some ownership over the research. It was also up to the participants to decide if they wanted a pseudonym

that was consistent with their gender, ethnicity etc. or not. Some participants took up this option whilst others were happy for me to decide on a pseudonym. Where I selected pseudonym, I chose names that were consistent with the participant's gender and ethnicity.

For those participants who I was interviewing via telephone, I emailed a consent form in advance and at the beginning of all interviews I explained the nature and purpose of the research and allowed opportunity for the participants to ask any questions. Prior to the interview very few, if any participants had questions, however, as the interview went on some participants asked about the research process I was taking as well as the theories and concepts I was using to frame the research. I suspect that this is unusual in other types of educational research as in this case all my participants had carried out educational research of their own. I suspect that in some ways this made the process smoother. They were familiar with the process of conducting qualitative educational research and knew how to adopt the role of research participant. This, along with the fact that my participants were well educated professionals meant that the interviews generally flowed well with participants providing full and detailed responses. In a sense, they knew how to '*play the game*'. However, because my interviewees were well informed participants, I also felt that there was a high level of pressure to do things correctly. In addition, some of the participants had been previous students of mine and I had taught them about ethical issues in research and how to conduct interviews. Therefore, I had to ensure that I practiced what I had previously preached.

Developing my interview technique

My institution focused study proved a helpful pilot project and provided some useful information about interviewing technique and how participants might respond to the types of questions I had planned. In advance of each interview I reviewed the interview schedule as well as my notes from the previous interview. In the early interviews this helped me to practice how I might phrase questions and to think about the best order for questions to be asked. After each interview I wrote an entry in my research diary and made a note of questions that I should follow up on more in later interviews. As a novice researcher this enabled me to reflect on process in order that I might improve my interviewing technique in subsequent interviews. I noted and reflected on questions that could be asked better, where I needed to rephrase a question in order for the interviewee to better understand, or where I had perhaps interrupted too quickly. For example, in my

interview with Helena, she made a comment which I found interesting and useful, and then developed in subsequent interviews. Towards the end of this interview, she commented that I had asked questions that she had not expected and that questions she had expected I had not asked. I thought that this was an interesting comment and therefore asked her to tell me about what she had been expecting me to ask about. In the previous interviews I always ended by asking participants if there was anything that they had not said that they would like to. Often participants responded negatively or they reiterated points they had previously made. Whilst this reiteration was useful in reinforcing certain points and/or in providing further concrete examples of a particular experience or type of practice, it did not always provide new information or insights. Following on from Helena's interview I changed this question slightly to ask if there was anything that I had not asked that the participant thought that I would have. If they said yes, I then asked them to answer their own question. This provided useful insights into what participants were expecting to be asked and therefore some ideas about how they thought about their professional identity development within medical education. I also rephrased the questions about gender differences in medical education once I realised that this was not an aspect of identity and practice that many participants have previously considered.

When transcribing my own interviews or when listening to those interviews which had been professionally transcribed, I made a note of where the participant laughed about a point or comment they had made. As Seidman (2013) suggests, interview participants often laugh because what they had said is funny or clearly a joke, or because they had meant something ironically. Seidman advocates following up on this and exploring the laughter further, because the meaning of the laughter may be hidden from the interviewer. I did not always feel comfortable with this approach or quick enough in the moment to pick up on it. However, I hoped that further discussion of the topic would reveal the hidden meaning behind the laughter. I also regularly asked participants for examples to illustrate a point they had made which was my version of Seidman's recommendation of asking participants to tell a story. As Seidman cautions, asking participants too overtly to tell a story will be off putting to some who think that they are not good story tellers. However, asking for an example seemed a more straightforward and less off-putting way of achieving a similar aim; that is to describe an experience in a detailed and concrete way. Examples also appeared to highlight some inconsistencies in participants' responses. For example, participants may describe an approach to their practice in what turns out to be a hypothetical or abstract way and a concrete example reveals that their actual practice is

not as congruent with this aim or approach as the interviewer may be led to believe if they had not asked for the example.

I also aimed to follow Seidman's advice to '*follow up but don't interrupt*' (p.88). To achieve this, I made notes of any points that a participant made that I wanted to explore further at a later point in the interview. This way I did not interrupt them but could also follow up on what I thought were interesting and salient points worthy of further exploration. Weiss (1994) advocates the use of echoing the participants' words and phrases to signify something of importance to them. For example, during many of the interviews I would say refer to something that the participants had said, using their terminology or phrase and then inviting them to say a little more about this or provide an example.

Other advice from Seidman that influenced my interviewing technique included avoiding leading questions and asking open questions. Often the open questions were broad such as '*can you tell me about what sort of teacher you think you are*' and required participants to think about a question that they perhaps not previously given much thought to or at least how they much sum up their thoughts in a meaningful way. I tried to preface these questions with an acknowledgment that they were broad questions, that they could be answered in any way the participants saw fit and reassured them that they could take some time to think about their response before answering. Advice that was more difficult to follow was Seidman's recommendation that interviewers should not reinforce participants' responses by saying such things as '*ok*', '*yes*' or nodding along in agreement, as the participant speaks. Although this demonstrates active listening and helps to build rapport, both points I agree with, Seidman argues that participants' responses could be distorted and these relatively minor verbal and non-verbal cues could lead participants in one direction or another. Furthermore, following Charmaz's (2014) advice I was mindful of avoiding generic '*umms*' and '*ahhhs*' which may have a similar influence on the participants, although despite this, it was clear when listening back to the interviews that I fell into this trap a few times.

Interview recording and transcription

As advocated by Forsey (2012), Seidman (2013), and Walford (2001) each interview was audio recorded and done so on two separate devices (normally a Dictaphone as well as an iPad) to prevent equipment failure. Seidman argues that recording interviews is important in order that the researcher may check for accuracy as well as demonstrate original sources

should this ever be required. Conducting the interviews in a quiet, private location ensured that the recordings were of good quality.

The audio recording of each interview was then transcribed in order to facilitate the analysis stage (Hammersley, 2012; Ng et al, 2014). I was fortunate enough to receive a small grant which I used towards getting five of the interviews transcribed. The interviews were transcribed full verbatim and therefore included ‘ums’, ‘ahhhs’, repeated words and half sentences, as I felt it was important to record these pauses, as well as laughter and so on. This, I thought, gave the content of the participants’ answers some context which was important to capture. In order to ensure accuracy and that I was familiar with the interviews, on receipt of the transcripts I listened to the audio recordings as I read the transcripts. I transcribed the remaining interviews myself, following the same requirements. Whilst this took a significant amount of time, it did enable me to get to know the transcripts well which aided analysis as I could move between and within the interview transcripts more easily. The interview transcripts were then emailed to the participant asking them for any comments or edits. As my participants were busy professionals, I gave them a two-week deadline and suggested that if I did not hear back from them within this time frame, I would assume that there were no changes that they wanted to make.

Once each interview was transcribed and I had received any changes from the participants or the two-week window had passed, I analysed the transcripts iteratively, reading and reviewing them as I went along. This process not only helped me manage the task within the time available and with multiple competing priorities, but also helped feed into subsequent interviews (DiCicco-Bloom and Crabtree, 2006). Whilst I did not change the interview questions significantly, analyses of previous interviews helped me to consider areas that might merit further probing or exploration in subsequent interviews.

3.7 Data Analysis

When analysing the interview transcripts, I broadly followed Corbin and Strauss’s (2015) instructions for thematic coding. As Babbie (2017) suggests, the key process in the analysis of qualitative data is to code the data, in this case the interview transcripts. Coding involves the classification of individual pieces of data within the text and therefore, initially this involved marking passages, comments or words of interest in the interview transcript. As Seidman (2013) advocates I did not spend too much time agonising over these initial parts of the analysis and each of these units were initially assigned a code. Sometimes these

were my own codes e.g. *'personal validation'*, whilst other times an *'in vitro'* code, that is a code from something interviewee said, captured the essence of this unit of meaning better e.g. *'black and white thinking'* (see appendix 8 for an example of coded interview transcript). Having assigned codes to the transcripts I began the process of grouping these into themes. Some of these related to the questions that I asked, for example about participants' motivation to do a Master's in Education or how they thought gender impacted on the roles and activities within medical education. Within these broad themes there were several sub themes. I was keen to try and illuminate the nuances within these larger themes and between participants' responses. I also tried to remain open to themes that were new in later interviews. Some of the interview transcripts were shared with my supervisor in order that we might discuss and, to a limited extent, verify the codes that I had generated. This was also a useful exercise to highlight codes or themes that I had perhaps overlooked or relationships between themes that had not been highlighted. Further verification of these codes and themes could have been undertaken by involving fellow EdD students or colleagues. However, the limited time available, as well as the fact that I wanted to maintain anonymity of the participants, prevented this.

As previously described, keeping a research diary also enabled me to reflect on how the interviewees responded to questions, for example particularly long pauses, laughter etc. or where the meaning of comments was sarcastic or ironic. This was important as I thought this might not be picked up on the audio recording and subsequent transcription, and that I may not remember when I came to analyse the transcripts.

'Particularly difficult interview. Didn't seem to provide a lot of detail. ?phone interview? Need to ask for more examples next time.'

'Lots to discuss in this interview. Realise that I should give more time to participant. Really helpful to get them to say what they thought I would ask about – lots of rich detail gained. Will definitely use this in future interviews.'

Extract from research diary after two of the interviews.

Alongside data analysis on the transcripts, I kept a separate notebook for *'memos'* (see appendix 9 for example). This enabled me to keep notes of my own response to the interviews e.g. aspects I that I found surprising or intriguing in some way, as well as thoughts about the differences between and within interviews. In addition, I could make a note of codes or themes that I wanted to look for in future interviews. According to Bryman

(1988) when analysing qualitative data, the aim is to '*go beyond pure description and to provide analysis...*' (p.61). This objective guided me in the analysis of the interviews and helped me to be open to the differences and similarities both between interviews and within each interview.

I chose to carry out the analysis of the interview transcripts by hand rather than using a computer software package. This was because I felt that analysing by hand gave me a more thorough familiarity with the data.

3.8 Participants

In total 15 participants were recruited and interviewed, with six males and nine females. The participants came from a range of different specialities, with the majority coming from a medical speciality such as dermatology and paediatrics (eight participants), five coming from surgical specialities, one general practitioner and one psychiatrist. They also ranged in experience and seniority from relatively junior doctors (two or three years post qualification) to senior consultants. As per the recruitment process, all participants had completed or nearly completed a Master's in Education or sub discipline such as medical, clinical or surgical education. The participants were involved in a wide range of education activities and held a range of different educational roles e.g. teaching fellow, course lead for an undergraduate or postgraduate programme, educational supervisor for postgraduate trainees and so on. Five of the participants were currently or had previously been teaching fellows based at a medical school or teaching hospital but in both settings focusing on teaching medical students. Two of the participants (Niamh and Helena) identified themselves as having a specific leadership role within a medical school, whilst one (Jackie) had previously had a named leadership role within postgraduate medical education. The sample reflected a range of specialties and bearing in mind that it is too small to draw any boarder conclusions, it did not indicate that these three Master's programmes were associated with any specific specialties.

The interviews took place between June 2016 and January 2017 and lasted between 30-65 minutes with the average being approximately 45-50 minutes. Below is a short description of each of the participants. Being conscious of maintaining anonymity, each has been given a pseudonym and the associated description does not include information which may make them identifiable such as their place of work, specific job title or precise specialty within which they work. The table also shows whether the interview was conducted face to face,

or over the telephone and whether the participant was already known to me, either because they were one of my own graduates and/or they were work colleagues.

Table 1 – Description of participants

Pseudonym and description of participant	Face to face or telephone interview	Gender	Known to me?
<p>1. Neil</p> <p>Neil is a professor of a medical specialty and was involved in a wide range of educational activities, from teaching on a first-year undergraduate medicine course to supervising PhD students. He completed his Master's in Education relatively late in his career and wanted to complete it for personal and interest reasons rather than strategic.</p>	Face to face	Male	Yes
<p>2. Ben</p> <p>Ben is senior surgical trainee. He is involved in teaching medical students in theatre, as well as teaching multi-disciplinary teams and co-supervising PhD students. He described himself as a surgeon who teaches, and described altruistic reasons for being involved in education. This interview was one of the shortest, as it was conducted between other commitments.</p>	Face to face	Male	Yes
<p>3. Clare</p> <p>Clare is a trainee doctor in anaesthetics who had returned to her postgraduate training having completed a teaching fellow job at a medical school. She was in the final year of her Master's in Education and had just returned to her clinical training.</p>	Telephone	Female	No
<p>4. John</p> <p>John is a surgical trainee who had also completed a teaching fellow job at a medical school and had completed his MEd during that time. He had also returned to his clinical training.</p>	Telephone	Male	No

Pseudonym and description of participant	Face to face or telephone interview	Gender	Known to me?
<p>5. Ali</p> <p>Ali is a trainee doctor in paediatrics. He is involved in a range of medical education activities, in particular organising teaching sessions for fellow trainee doctors and in simulation activities. He had completed his MEd in the previous year.</p>	Telephone	Male	No
<p>6. Jackie</p> <p>Jackie is a consultant working within a medical specialty. She mainly works within postgraduate medical education as both a clinical and education supervisor for several trainees. She had previously been a training programme director (someone who co-ordinators the programme for trainee doctors within a local area for a particular specialty and manages the review and assessment of these trainees). She has recently completed a Master's in Education and was now working as a tutor on that course.</p>	Telephone	Female	No
<p>7. Helena</p> <p>Helena is a General Practitioner who also works as an academic within a medical school. She is mainly involved in undergraduate medical education and has developed and runs specialty choice modules in medical education for students.</p>	Face to face	Female	Yes
<p>8. Louise</p> <p>Louise is a junior doctor, currently taking time out of training to work as a teaching fellow at a medical school. She is involved in curriculum design projects as well as teaching ethics and law to undergraduate medical students. She also works one day a week in a clinical specialty.</p>	Face to face	Female	Yes

Pseudonym and description of participant	Face to face or telephone interview	Gender	Known to me?
<p>9. Judith</p> <p>Judith is a consultant within a surgical speciality. She had previously had a role as a personal tutor and mentor to undergraduate medical students as well as involvement in simulation. However, she had given both of these up as she felt that she was doing too much. At the time of the interview, Judith was both an educational and clinical supervisor to a small number of trainee doctors.</p>	Telephone	Female	No
<p>10. Hema</p> <p>Hema is a teaching fellow at a teaching hospital. She is responsible for organising the delivery much of the teaching for medical students who are placed at the hospital for their clinical attachments. She has done that role for a significant number of years and was yet to complete her clinical training (gain her Certification of Completion of Training). However, she continues to work clinically one day a week.</p>	Face to face	Female	Yes
<p>11. Niamh</p> <p>Niamh is a consultant in a medical specialty. She is mainly involved in undergraduate medical education at a medical school and has been involved in redesigning a curriculum within her specialty for medical students.</p>	Telephone	Female	Yes

Pseudonym and description of participant	Face to face or telephone interview	Gender	Known to me?
<p>12. Natasha</p> <p>Natasha is a consultant in a medical specialty, but who now has a role within a medical school at a university as a clinician scientist. When working in a clinical context she was more involved in both undergraduate education (teaching medical students who can to the wards) as well as postgraduate education of trainee doctors. Her current role means her focus is on producing research output but she still supervises both undergraduate medical students and Master's students doing research.</p>	Face to face	Female	Yes
<p>13. Sabrina</p> <p>Sabrina is a trainee surgeon, currently in her final year of training and practicing outside of the United Kingdom. She is currently in the final year of her Master's in Education which she is studying in the UK. She mainly teaches medical students and more junior doctors on the wards and in the operating theatre, but has recently become more involved in running simulation activities for medical students.</p>	Face to face	Female	No

Pseudonym and description of participant	Face to face or telephone interview	Gender	Known to me?
<p>14. Justin</p> <p>Justin is a consultant psychiatrist who completed his Master's in Education 5 years ago. He is involved in the postgraduate education of doctors, acting as an educational supervisor for two trainee doctors. He is involved in the education of medical students. He delivers lectures on psychiatry, teaches students when they are based with him on their clinical attachments, and acts as the personal tutor for a small group of junior medical students.</p>	Telephone	Male	Yes
<p>15. Rohan</p> <p>Rohan is a consultant surgeon who completed his Master's in Education 15 years ago. He is mainly involved in postgraduate education and with senior trainee doctors who he teaches and supervises. He is particularly involved in the development of curriculum and training for his particular sub specialty. He occasionally teaches undergraduate students who sit in with him during outpatient clinics</p>	Telephone	Male	No

3.9 Conclusion

This chapter has outlined and discussed the various methodological decisions taken in conducting this research. The methodological approach adopted was broadly a social constructivist one, drawing on elements from critical social theory. I was mindful of my own positionality as a researcher and attempted to be explicit about this and reflexive about the impact that this would have on the research. Ethical approval for the research was granted by both King's College, London and Imperial College, London. The main ethical issues considered and addressed included, informed consent, confidentiality, the right to withdraw from the study and the minimising of coercion to take part. Interviews were chosen as the main data collection method in order to capture the personal nature and complexity of individuals' professional identity development. 15 participants were recruited via both volunteer and snowball sampling, all of whom had completed or nearly completed a Master's in Education. Interviews were conducted either face to face or by telephone and were audio recorded and transcribed. The interview transcripts were then analysed using thematic coding.

The following chapter presents the main results from this data analysis

RESULTS

4.1 Introduction

Having analysed the interview transcripts, this chapter discusses and analyses the key themes and findings from these interviews. The approach taken in this chapter is to present these themes with selected quotes used to illustrate the key points (Burnard et al, 2008; Kvale, 1996; Savin-Baden and Howell Major, 2013). This approach was adopted because of the iterative nature of the research methodology used for this study. The results are divided into five sections; the first of these, section 4.2 considers the different communities of practice within medicine, including analysis of websites and journals to demonstrate these differing views of education within medicine. Section 4.3 discusses the range of educational activities that participants were involved in and whether education may be considered multiple communities. In section 4.4 the work of identity development experienced by participants, their experiences of crossing between these two discipline area and the impact on their identity of studying for a MEd will all be discussed. Section 4.5 considers participants experiences of the status of education and discusses examples where, counter to much of the literature, it was considered to be a high status activity. Finally, section 4.6 discusses gender differences experienced by these participants, and whether participants thought that there were differences between medical educators.

4.2 Medicine as a constellation of communities

As discussed in the literature review of this thesis, communities of practice are considered by Wenger (1998) to have specific characteristics; namely joint enterprise, mutual engagement and shared repertoire. Medicine is considered by some authors as one community of practice given that the members within this community engage with each other in specific ways (Cruess et al, 2017), and particularly when compared to other professions. For example, medics have their own language and terminology, types of relationships with others e.g. patients and so on. However, other authors such as Cantillon (2016) have argued that within medicine there are multiple communities of practice. The type of practices that a surgeon would engage with, for example operating on a patient under anaesthetic, are considerably different to those of a psychiatrist, who may primarily focus on talking with a patient. Therefore, the aim of these first two sections is to explore whether medicine and education are made up on several communities (or constellations of communities). This is done in this first section (4.2), by presenting contextual information from the websites of medical professional bodies as well as discipline specific journals to

consider how different medical specialities view education and present it to those within their speciality. In order to explore the range of communities with education, the subsequent section 4.3 presents a discussion of the differing educational activities that participated engaged with will be presented, for example, teaching students, colleagues, and patients, in both clinical and non-clinical settings. These differing medicine and education communities may have varying similarities, thus making it more, or less, straightforward for participants to broker between these communities.

Review of websites and journals

In order to provide some additional context to the participants' interviews and further detail about these different communities of practice, as well as to understand more about the messages that participants might be exposed to about education within their speciality, I undertook a review of the websites of a range of professional membership organisations as well as some medical journals that included articles on education. This section outlines the process of undertaking this analysis before discussing the findings and how these link to the participants own experiences.

For the review of websites, I selected the Royal Colleges of General Practitioners, Surgeons, Psychiatrists and Physicians as most participants I interviewed were likely to be members of one of these and there have some links to them. These medical Royal Colleges are professional bodies with responsibility for the training of doctors within a specific specialty or range of specialties. As the Academy of Medical Royal Colleges (AoMRC) states, the remit and expertise of the various Royal Colleges is in driving *'improvement in health and patient care through education, training and quality standards'* (AoMRC, 2016). During April 2016, I reviewed each of the websites noting the appearance of terms related to education such as *'education'*, *'training'* and *'learning'*. I made notes as I looked at each of these websites and adopted a similar approach to the way in which I reviewed them. Initially I started with the home page and noted any reference to education or related terms. Secondly, I then looked at courses that the Royal College offered and again noted any that were on education or teaching. Thirdly, I looked at their annual conference and reviewed the conference programme both for the forthcoming conference if available and/or the last conference. Again, I noted any references to education and where these occurred. Finally, I reviewed the website for any other reference to education, training, teaching or learning by using the search function on each of the websites. The following

table summarises these key features and how these are presented on each of the websites reviewed.

	Royal College of General Practitioners (RCGP)	Royal College of Surgeons (RCS)	Royal College of Psychiatrists (RCPsych)	Royal College of Physicians London (RCPLondon)
Education terms on website homepage	<ul style="list-style-type: none"> ● Training ● Learning ● eLearning ● EPortfolio 	<ul style="list-style-type: none"> ●Examinations ●Courses 	<ul style="list-style-type: none"> ●Training ●Examinations 	<ul style="list-style-type: none"> ●Education
Education and teaching courses	<ul style="list-style-type: none"> ●Online teaching learning and assessment course 	<ul style="list-style-type: none"> ●Training the trainers – developing teaching skills ●Training and assessment in the clinical environment 	<ul style="list-style-type: none"> ●Training days for educational and clinical supervisors 	<ul style="list-style-type: none"> ●MSc in Medical Education (one homepage) ●Doctors as Educators courses listed under education heading
Conferences	<ul style="list-style-type: none"> ●No reference to education in main conference, but medical education group (MEG) conference. 	<ul style="list-style-type: none"> ●Annual Surgeon Educators conference 	<ul style="list-style-type: none"> ●Postgraduate medical education conference ●International Conference that included an education stream 	<ul style="list-style-type: none"> ●Medical education conference ●Annual conference included sessions on mentoring, assessment, curriculum updates and 'education, training and medical professionalism
Other references to education	<ul style="list-style-type: none"> ●Recruitment advertisement for an 'Educational advisor' to advise on seminar series ●Recommended medical education books 		<ul style="list-style-type: none"> ●Public Education Board ●MindEd – an elearning tool for young people. 	

Table 2 – Review of medical Royal College websites

All the medical Royal Colleges have some role in the promotion of their speciality and patient care through education and training and, as can be seen in Table 2, all the websites made some reference to educational terms on the homepage. There were some differences in the terms used on the homepage, with the Royal College of Psychiatrists (RCPsych) and the Royal College of General Practitioners (RCGP) referring to '*training*' and the RCPsych and the Royal College of Surgeons (RCS) referring to '*examinations*'. In addition, on the homepage of the RCGP were links to '*eLearning*' and the '*ePortfolio*', an online portfolio that GP trainees are required to complete as part of their training programme. Only the Royal College of Physicians London (RCPLondon) used the arguably broader term of '*education*' to signpost the courses and services on offer to their members. Links on the homepage of a website are often there for easy access and therefore may be representative of what the organisation thinks is important, or what those using the website need access to most frequently.

The RCS made no reference to '*training*' or '*education*' on the homepage of the website although under the link to courses there were two education courses listed – '*training the trainers- developing teaching skills*' and '*training and assessment in the clinical environment –TRACE*', alongside courses on surgical skills. Both these courses were designed to cover the General Medical Council (GMC) standards for the recognition and approval of postgraduate trainers. The RCPsych and RCPLondon website also listed training days for educational and clinical supervisors (those responsible for the training of postgraduate trainees). Many of the courses are, to some extent, mandatory, in that in order to act as a trainee's educational supervisor a consultant would need to be appropriately trained which generally involves attendance at a training session or sessions for educational supervisors. Attendance at a teaching skills course (or similar) is also often required for trainee doctors' applications for their next stage of training. The RCPLondon homepage also had a prominent advertisement for their MSc in Medical Education although this may have been temporary posting as the deadline for applications was in one month's time.

All the websites referred to education specific conferences that they organised, with the RCPsych and RCPLondon also having educational streams within the College's main annual conference. For example, the RCPsych International Conference was a four-day conference which included one stream on one day on education and included sessions on global mental health, curriculum reform and recruitment to psychiatry. The RCP annual

conference also included sessions on mentoring and leadership, and a stream of workshops on *'education, training and medical professionalism'*. These sessions covered topics such as assessment, postgraduate training and curriculum updates. The annual conference programme for the RCGP revealed little or no reference to education topics, although there was a medical education group (MEG) conference which was held at a time to overlap with and continue after the annual conference. Workshops at this conference were divided into the themes of *'nurture'*, *'enhance'* and *'share'*. Presentations from the previous MEG conference in 2012 were available on the website and included presentations on the topics of mentoring, encouraging undergraduate students into general practice (recruitment) and learning styles. The programme for the 2016 annual surgeons' conference at the RCS listed talks and presentations on emotional resilience, theatre team training and educating the educators. The RCPLondon one-day medical education conference addressed a range of topics within education. These included:

- *'medical education – the patient at the centre*
- *tomorrow's doctors, tomorrow's leaders*
- *the trainee – supervisor partnership*
- *assessment – what's on the horizon?'*

Finally, the RCPsych referred to the *'Public Education board'*. Within this public education section on the website there was reference to an elearning tool called MindEd which aims to educate young people about mental health. This was the only website to refer to education of the public.

Whilst educational terms and events appeared on all the websites this, albeit small, review hints at some similarities and differences in how these are educational activities and events are presented and how integrated these are within the clinical aspects of a specialty or specialties. For example, some of the websites and conference programmes suggested that education was a specialist interest area rather than something that all doctors should do, whilst for others it was more prominent and integrated. All the websites advertised educational courses but these were not always presented prominently.

In addition to looking at the websites of the different medical Royal Colleges I also reviewed different speciality based journals for the number and type of education articles that were published in them. This helped to further ascertain the prevalence and prominence of education related topics within different specialities. Dimitroff and Davis

(1996) found that just less than 60% of articles on topics related to undergraduate medical education were published in specific medical education journals with about 20% being published in specialty specific journals and 14% published in general medical journals. Although the majority of medical education articles appear in medical education specific journals, I chose to look at the specialty specific journals as I was interested in how educational research and topics were represented within the specialties.

I reviewed journals for the period January-April 2016 noting the number and types of education articles that appeared in each issue during this period. The journals I chose to review were the *British Journal of Surgery*, the *British Journal of General Practice* and the *British Medical Journal*. None of these journals were specifically education or medical/clinical/surgical education journals such as *Medical Teacher* or *Medical Education*, however they all had an education strand or published education focussed articles. For this period the *British Journal of Surgery* (published monthly) published three articles related to education. All three of these articles were evaluations of training tools designed to help trainee surgeons develop their skills in a specific procedure. Within the *British Journal of General Practice* (also published monthly) there were four articles on education for the same period. Whilst this was a similar number as the *British Journal of Surgery*, overall there was more reference in other articles to patient perspectives, humanities, philosophy and ethics in addition to the articles specifically on education. Finally, the *British Medical Journal* is published on a weekly basis rather than monthly and so there were more articles on education. However, these appeared more likely to be letters or editorials on policy related to medical education such as the Shape of Training Report, recruitment, continuing professional development, and examinations, rather than primary research on a medical education topic.

Review of these websites and journals suggest that there are some differences in how educational ideas are presented and discussed within these different specialties. Within surgery there appeared to be a greater focus on training and training tools and adopting a more quantitative approach to educational research, whilst within the primary care journal there appeared to be a wider discourse about education and related subject areas such as humanities. These may be reflective of the nature of these two specialities; general practice taking a more holistic approach to patient care, whilst surgery is more focused and precise about a specific aspect of patient care. The differences in the types of articles on

educational topics published by a surgical journal and those published by a journal on general practice, suggest that there may be differences in the way in which education is viewed and what underlying assumptions about education exist within different specialities.

The view from the specialities

Differences in how medical specialties viewed education were also reflected in the participants' interviews. Surgery was highlighted by both surgeons and non-surgeons as having a specific view of education. For example, John (a surgeon) described how he thought there was a traditional view of education amongst surgeons, citing the presence and common acceptance of didactic teaching. This was also identified by Helena, a general practitioner, who commented,

'I mean it tends to be the surgeons that you hear speaking that are more didactic in their approach towards teaching...'

Surgery therefore appeared to have a shared repertoire (Wenger, 1998) of didactic teaching that was identifiable by both surgeons and non-surgeons. In contrast, Justin, a psychiatrist, explained how he thought that psychiatry and education were more overlapping disciplines than when compared with other specialities. He described how he thought psychiatrists,

'have a particular interest in working with people, working with change...are interested in systems and the bigger picture, are interested in working with the grey and uncertainty. There is quite a big overlap between psychiatry and education. Both...have a real fundamental commonality in trying to help and support people to change.'

Louise also noted differences between specialties and their approach to education. She described her experience as a medical student in different specialities comparing paediatrics, which was *'just lovely'* and where *'everything was very nurturing, everything was very organised'*, with surgery which was,

'also great but...they are like, right you're part of the team, come here, do that. And you think, oh my god, I don't know what I'm doing.'

This quote suggests that her experience as a learner in surgery was more hands-on, with less scaffolding but for her this did not necessarily mean a less effective learning experience.

These quotes suggest that some of the participants could identify different approaches to education by different specialities with surgery being a notable example and psychiatry being given as an example where the joint enterprise (Wenger, 1998) was similar to that of education. These different views and approaches are likely to impact on how participants engage with education and the associated challenges that they might face in doing so.

4.3 Education as a Constellation of Communities

The previous section considered how different medical specialities may have different views of education and how these views were communicated through websites of medical Royal Colleges and in medical journals. Following on from this, this section considers the range of educational activities that participants reported engaging with, and therefore, like medicine, how education may be made up of multiple communities. Despite all doctors being required to be involved in teaching and education, the nature and type of activities as well as the level of involvement varied amongst the participants. This suggests that education is not one community with a shared repertoire of practice. Therefore, when we use the term '*medical education*', we are potentially talking about many different things. For example, teaching undergraduate or postgraduate students, teaching in a clinical setting e.g. whilst seeing patients or in a non-clinical setting such as giving a lecture.

All the participants could describe the teaching and educational work that they were currently involved and even those who thought they were not doing very much educational work were still teaching or examining. For example, as Clare explained,

'currently not that much (teaching), just because of how much time the Master's is taking up. At the moment, I'm mainly just doing examining for OSCEs (objective structured clinical examination) ...and a bit of mentoring of final years (medical students) that come through. But actually, because I'm doing an anaesthetics and intensive care rota and had the Master's, this year has probably been the least I've done.'

Some participants had specific, named educational roles which normally involved responsibility for a particular aspect of medical students' or trainee doctors' educational experience. For example, Niamh was responsible for part of the undergraduate year 5 course at a medical school. These participants would often have a specific job title and associated remuneration for these roles. Other participants had less formal roles such as teaching students in a more ad hoc manner when students were on the ward or observing an outpatient clinic. These less formal teaching activities were also done by those who had more defined educational roles. For example, Louise described how in addition to her

formal education role as a teaching fellow at a medical school, when she was working clinically she would also teach students who were on the wards at the time.

Whilst most commonly participants discussed teaching students or trainee doctors as the major part of their education role, some also described teaching colleagues or other team members, with relatively fewer describing teaching patients as part of their educational role. In order to better understand the variety of ways that participants engaged with education, each of these teaching activities will be described in more detail, with specific examples from participants' interviews to illustrate these further.

Teaching students

Generally, the participants' teaching and educational experiences most broadly focused on either undergraduate medical education e.g. they had a role within a medical school or they taught medical students in their clinical workplace, or on postgraduate medical education e.g. they were involved in the training and development of qualified doctors who were still in training. Examples of involvement in postgraduate education also included supervision of Master's and/or PhD students. A small number of participants were involved in both undergraduate and postgraduate education. For example, both Ben and Neil taught undergraduate students but also supervised PhD students who were undertaking study in their specialty area.

Within both undergraduate and postgraduate education, some participants had specific areas of responsibility, for example, Helena was the curriculum lead for student speciality choice modules. This was where a student would choose a three-week attachment in an area of interest, such as medical humanities or ethics and law. Within postgraduate education, Jackie had previously been a training programme director. This role involved her being responsible for junior doctors training in her specialty area within a specific geographical location. Jackie commented that she *'really enjoyed a lot of that (role).... training people to be good clinicians and good colleagues.'*

A further distinction was between clinical and non-clinical teaching activities. Many of those participants who were working clinically were involved in teaching students and/or trainees in those clinical settings. This type of teaching often involved a small number of medical students attending a ward round or sitting in on an outpatient clinic and in addition to treating the patients, the doctor would also be expected to ensure that this was a useful educational experience for the students. Non-clinical teaching activities would normally

involve giving lectures or running small group tutorials often away from a clinical setting. These tended to be planned and timetabled, and generally less ad hoc in nature.

For most participants their involvement in education had increased over time, in that they took on more responsibility for educational activities such as becoming a course lead, or the range of educational work had broadened. For example, Neil commented that he was now doing more undergraduate teaching whereas for a long time his focus had mainly been on training postgraduate doctors and supervision of PhD students. Ali also found that his educational activities had increased in quantity and range, partly because he was a more senior trainee doctor, but also because he had just completed his Master's in Education and was therefore looked at as someone with relative expertise and interest in this area.

'I've always been, throughout my career, been doing some kind of teaching. And (I've) certainly been more...sort of, coordinating teaching rotas, things like that. And, I think as I've become a bit more senior, and started to have an interest in education, then people ask you to do things.'

For a small number of participants their educational activities had decreased, often when their clinical responsibilities had increased. As mentioned above, Clare had returned to clinical training and therefore, in comparison to her teaching fellow role that she had previously worked in, she was doing considerably less education work, whilst Jackie had also stopped being a training programme director because of a lack of time.

Teaching colleagues

In addition to teaching students, several participants described teaching their colleagues, including trainee doctors, as one of their educational activities. These trainees would be working more independently, perhaps seeing their own patients, but with the more senior doctor (normally a consultant) being expected to check their work and help develop their expertise and experience. Along with teaching surgical trainees, Rohan described how he also taught general practitioners about aspects of his specialty. A further example was from Ali's interview where he described a situation where teaching for his whole clinical team was timetable for once a week and he often took a lead in these sessions. Ben also referred to teaching nurses and other health professionals whilst in the operating theatre, whilst Louise described a teaching session that she ran for the nurses on the ward about oxygen equipment use. Hema, who had been working primarily as a teaching fellow for the past

nine years, gave the example of teaching her new teaching fellow colleagues. These colleagues were typically trainee doctors and would stay in this post for a year or two. They were most often junior to Hema in both their stage of training but also in their level of experience and expertise in education. As Hema explained,

'Apart from that (teaching students) I have another two teaching fellows. So, I look after them as well. So, I teach them sometimes if they're not really sure what to do, that kind of thing. So, I like try to give them teaching materials, sometimes teach them, demonstrate to them.'

Whilst this was not a formal part of her job role, she was keen to develop herself in this role and therefore took it upon herself to help others develop their professional practice albeit in an informal way. As a more senior colleague, these teaching fellows also looked to Hema as someone who they could ask for advice about such things as the best way to design a teaching session or how to assess students.

'...like if somebody comes with a problem in the department, I would listen to it and it would just pass me. Now I feel like I have a responsibility, not a responsibility but like I can help, so I would say, let's think, I'm sure we can work out a way. So, I started like maybe expanding my own role, beyond my job description maybe.'

Teaching patients

Finally, although the term doctor derives from the Latin term *'to educate'*, only Louise and Niamh talked about teaching patients has part of their educational role. Early on in her interview Louise had talked about wanting to become a teacher prior to studying medicine but had dismissed teaching as being *'too academic'*.

'Part of me always wanted to be a teacher but I didn't feel academic enough to say be a secondary school teacher because found secondary school quite hard. And I thought primary school, you have to know loads of different things so there's no chance I'm doing that! (laughs). And so I went and did medicine and I realised that a lot of your role is actually educational in terms of patient contact, you're teaching them about their disease or educating them about why you're doing a procedure. And I thought, I quite like this I quite like breaking down concepts.'

This perhaps reveals something about the identity and role of a doctor that was not clear to her before entering the profession. However, for Louise education appeared to be a key part of her professional identity as a doctor. Niamh also discussed having a role in educating her patients and how she would need to adopt a different approach or style to when she was teaching her medical students. This exchanged revealed some of the complexity of teaching both students and patients and the different approaches required.

Niamh - 'So I know we teach undergraduates, postgraduates, nurses etc. but all the time in our consultations we teach patients so that's, you know you have to explain things to them and make sure they understand. Anyway....

JH - No, I think that's a really important.... Do you think you take a similar approach with your patients as you do with your students?

Niamh - Well, you try not to because that can land you into all sorts of hot trouble really. But sometimes you, sometimes you do and what happens when you're teaching the students and the patient's there and the patient joins in. Or you'll say, you'll say to the students 'What's this there?' and then the patient will try and answer. Which is really quite funny you know? But it's really nice, honestly, it's their consultation, they're in the room, but sometimes likewise that can cause a rub having the students in the consultation.

JH - And do you therefore think that you have to be a bit more directive with your patients, you know, a bit more...?

Niamh - Well it's different, isn't it? Because with students you can sort of quiz them and test them and that sort of thing if need be but with patients obviously you have to be careful that you don't rub them up the wrong way and they're vulnerable and so it's totally different. And that's sometime quite a juggling act actually. Everyone will tell you this I'm sure, the juggling act between the patient and the students, but even the teaching of the patient and the teaching of the student, there's some.... you know, interesting elements there because.... Well that can go on at the same time and that can be quite fun. The patients like teaching the students as well. You can have the patient do the teaching for the students and you just stand there. And they're the best ones. The students will listen to the patient much more than you

JH - But I imagine you have to be quite happy to almost oscillate between two quite different approaches when you've got the patients and when you've got.... students

Niamh Yeah, that can tax. That can be difficult. Yeah, yeah and sometimes you get it wrong (laughs).'

In this exchange she highlights the different approaches she feels she needs to adopt with each group, as well as some of the difficulties in this teaching scenario. However, she also saw the value in involving the patient in the teaching session.

I was surprised that not more of the interviewees commented on teaching patients as one of their educational roles and I wondered why this might have been. Perhaps it was genuinely that they did not see the education of patients as part of their role, or that it was more challenging to teach patients given the time and resource constraints on clinical practice. However, it may have been because of the nature of this research e.g. who I was (although I did not say much about my background during the interview, many of participants knew me and therefore were aware that I had an academic role at a university and had a non-clinical background), the topic under discussion and perhaps because I had recruited them because of their Master's study that they did not refer to patient education. In my experience, few Master's in Education students, if any, had undertaken projects

around patient education, often because of the more complex ethical approval process for this type of research. These factors might have orientated them to a way of thinking about their educational role during the interview.

Summary

All the participants in this study engaged in educational activities in a variety of ways. Most were engaged primarily in undergraduate or postgraduate education, with a small number of participants involved more equally in both sectors. All spoke about teaching those more junior to them, either students and/or trainee doctors in a range of settings. Some participants referred to teaching colleagues as part of their job role and this included more formal teaching, such as teaching team members on a weekly basis or more informal ways, such as mentoring new colleagues. Finally, a small number of participants discussed teaching patients. This did not appear to be an obvious part of their doctor identity. There was added complexity when teaching both students and patients as, according to Niamh, different approaches were required.

Given the range of educational activities that participants engaged with, plus the differing settings and different roles, it may be that education in this context is made up of a variety of communities.

4.4 Crossing paradigms - The work of identity development and the impact of studying a Master's in Education.

The themes from the participant interviews appear to support the idea that not only is medicine multiple communities but so is education. Participants in this study had decided to engage more with education as a discipline through completion of their MEd and this section will also consider how the process of studying for this qualification, as well as the qualification itself, facilitated the boundary crossing between their medical community and their education community. For many participants studying for a MEd did not appear to be straightforward and therefore this section initially considers the challenges that they described in the interviews. However, a further theme from the interviews was that completion of a MEd also brought about positive aspects for most of the participants, including validation for themselves as an educator, as well as changes in practice. Many participants studied for a MEd because of a desire to engage more with education and therefore post MEd trajectories, or lack of, will also be discussed.

Challenges of studying education

Wenger (1998) described the difficulties of moving from one community of practice to another and brokering between the two as being both complex and challenging. Within medical education, the challenges of moving from a primarily positivist scientific paradigm to a more interpretivist one of education have been described by Kneebone (2002) and specifically in relation to engaging with qualitative research methods by Woolf (2006). The majority of participants described difficulties that they had in engaging with this new paradigm and of working across two communities of practice. For Hema, despite her educational identity seeming to be prominent for her, the transition to working within an educational paradigm had not been straightforward.

'It was challenging. I was kind of almost in tears during the Diploma year (year 2 of MEd) at some stage (laughs). But then when you pass that, you kind of start seeing, oh its ok.'

Other participants could provide specific examples of aspects of education that they found difficult. Judith provided the example of what to refer to her trainees stating that,

'I still find being called a learner really hard, they're trainees. I find the term learners really hard and funny.'

She went on to explain that she thought education suffered because it had a particular image – 'cuddly' - and that the use of terminology made education difficult to access for those from different discipline backgrounds.

'Cuddly, no one can fail.... Schools now don't have sports days because you can't have people who win or excel... it's just leads to mediocrity in my mind.... And I'm afraid some of the terminology that comes out of medical education makes my toes curl because it makes me think of those sorts of things.'

Neil also referred to educational concepts as being dressed up 'in fancy terminology and stuff' suggesting that perhaps this terminology was unnecessary. Judith also described the challenge of familiarising oneself with educational terms particularly because,

'the word theory means something different...I felt that I walked...into Alice in Wonderland, where Humpty Dumpty says when I use a word it means what I say it means.'

It was clear from several participants that the different terminology and language (shared repertoire) of education provided a barrier to engaging with this new community of practice.

Views of, and approaches to, educational research

A further challenge of engaging with education was the approach to research within this discipline. Most Master's in Education programmes require students to undertake their

own educational research, and for most, this is the first time they have encountered such research methods. As was seen in the review of journals, there also seemed to be a view of what was valued as educational research, with medical education researchers receiving messages about the higher value of large scale, randomised trials compared to qualitative research. From my own experience, as well as that of some of my own Master's students, qualitative research has often been rejected based on having a small sample size, not having objective outcomes, or not being a randomised control trial (see Golub, 2016 for example). Sometimes students are weary of conducting qualitative research for their MEd projects because they want to get a publication from it and are concerned about what might be accepted by journals or be palatable to their colleagues (Albert et al, 2007).

Engagement with educational research methods was commented on by many of the participants. For some, this was an enjoyable and valuable aspect of their studies, although for many this presented challenges with adopting a new methodological approach. Much like Woolf (2006), John described how he came to change his view about the worth and validity of qualitative research.

'I remember being very resistant to the concept of thinking of medical education research as valid. So, anything that wasn't positivistic research was, for me, invalid.'

Here John's comments support the view of Bligh and Parnell (1999) and Gill and Griffin (2009) amongst others, who argue that greater prestige is placed on research utilising quantitative methods. However, it was the process of conducting educational research that helped him to see the value in the methods used.

'I think it was the process of going through the course and being exposed to more qualitative research and gradually coming to an understanding of what that actually meant.... In the certificate year (year 1), I tried to be quite quantitative. I'd say positivistic approach and tried to mix it with qualitative methods.... I mean it was...it wasn't a disaster, but it was, it was quite a struggle and like, it wasn't a very nice research experience.'

He also described the difficulty in getting approval for educational research from senior colleagues who were not as familiar with the educational research methods or evaluation techniques that he was proposing. This supports Pirrie's (2000) view regarding the difficulty of developing good quality educational research because of the prevalence of the biomedical approach to conducting research. Clare also experienced some less than positive views from her colleagues about her MEd research, particularly when she revealed that in her dissertation she took a qualitative approach to her research.

'And other ones (other colleagues), when I'm saying, 'oh god, I'm writing my Master's thesis', they initially show a lot of interest.... And when I say, (it's in) medical education, and they're like, oh right. And then...I say its qualitative research. And they're like, oh.'

The way she said this indicated that they were not very impressed by her studies and went on to explain that she thought that in their view *'it is worth less than a Master's in... cancer cell biochemistry or something like that.'*

It was clear from many of the interviews that there was a tension between the approaches to research in these two communities of practice and was one that participants needed to resolve in some way. This was either by trying to adopt a more quantitative, positivist approach to their educational research because they were yet to fully appreciate the benefits of a more interpretivist approach in answering educational research questions, or they were aware of this but were keen to get their research published and therefore followed the norms of biomedical research in order to achieve this. Alternatively, they adopted a more qualitative approach that was better aligned to their research question, but an approach that might make it more difficult to get their research published.

Validation

Despite these challenges that some of the participants encountered, there were also positive aspects of completing a Master's in Education. For many of the participants, one of the positive outcomes was that it provided them with some form of validation. This validation appeared in two main ways with participants referring to both institutional validation, as well as personal validation for themselves as a professional.

In terms of institutional validation, Neil referred to completing his MEd as ticking a box for the institution and *'that must please somebody somewhere.'* Helena described how her head of department recommended that she did the MEd course and for some participants who had undertaken a teaching fellow post, completion of at least a Postgraduate certificate (PGCert) level qualification in education was a requirement of this role. Sabrina also had explicit support from a senior colleague explaining that,

'...one of professors in my university hospital wanted to take this course himself but he didn't have time and he wanted someone on his team with this degree, so he gave me the opportunity to do this.'

Jackie linked her qualification to broader policy such as the General Medical Council requiring educational supervisors for postgraduate trainee doctors to be accredited, and that this was one way of achieving this.

Whilst these reasons did not appear to be primary motivators for undertaking postgraduate study in education, they appeared to be helpful in providing external motivation and validation. However, personal validation from the qualification appeared to be more impactful on participants' identity as an educator and how they engaged with an educational community of practice. For example, Jackie commented that having a qualification was important because it demonstrated that, speaking about herself, *'she does actually know what she's talking about.'* Similarly, Louise also felt that her qualification *'empowered'* her to talk about improvements in educational provision with her colleagues and that educational theory underpinned what she was saying and therefore gave her suggestions more credibility. Sabrina also described how she was more confident in teaching students whereas before she thought that they were best taught by subject experts, which she did not consider herself to be. As she explained,

'now because I tend to think that because I was in that stuck place not so long ago I might be better at explaining some points to them. So, I tend to speak up earlier now and I feel more confident in teaching them how to do certain things.'

Neil also referred to personal validation saying that,

'...it (completing his MEd) does make me feel that I can talk about these things in a way that maybe I would have felt more diffident... I still feel diffident but more diffident (before the MEd).'

Hema referred to an increase in her own confidence several times during her interview.

'Because as I said to you before I feel more confident that I have a...proper teaching thing (qualification).'

Niamh also described how, if someone was involved in education in any significant way, it was important to have some relevant theoretical underpinning to this aspect of practice.

'Well I suppose if you want to be doing something and spend more, a greater role in it in your, in your career, and you are from a fairly academic background as most people are in professional lives, you have to be able to show some understanding of academic side of whatever it is. So, you have to be able to show your credentials in some way I suppose. So yeah, I suppose it was to get some credibility. Feeling I needed to earn my stripes...'

Therefore, despite education sometimes appearing to have a lower status than other aspects of practice, a feature that will be explored further in the subsequent section, many

participants clearly gained validation from completing their Master's in Education. One reason for this is that such a qualification supports individuals in their brokering role. Wenger argues that those who engage in brokering work are constantly reconciling their identity and that achieving a postgraduate degree helps participants to engage with a community of practice of education and therefore support this aspect of participants' identity.

For some participants this increased confidence and validation impacted on their practice as educators or the opportunities that they chose to act upon. As previously discussed, Hema gave the example of how she now felt more confident in helping colleagues with their own educational practice or queries. Helena also described how this personal validation helped her to develop new modules for undergraduate medical students, stating that,

'It (the MEd) gave me some validity as a teacher...So internally I thought, oh yes, I've done the master's in education. I understand a little bit about educational research. I understand how to approach things, so it kind of gave me more validity, which helps a lot you know. So that kind of helped me think, yes I can create my own modules or do things how I want to do them...'

Neil also gave an example of how the having a postgraduate qualification in education gave him confidence to take up the offer of inspecting teaching at an overseas university.

'An example would be that I was invited to go to (names location) to inspect the teaching of (names specialty area) And I wouldn't have gone if I hadn't have been doing this course at the time. I would have just felt, 'what do I bring to this?'

However, this positive validation was not universal amongst the participants. Some participants did not find aspects of their MEd as useful as others. For example, Clare felt that during first stage of her Master's course (Postgraduate Certificate) she learnt *'little more than during a two-day teaching skills course'*. In contrast, Judith felt that there was little benefit to the final stage of her Master's course where she needed to complete a research based dissertation and that she had already *'learnt everything that I needed to learn.'* Furthermore, some participants also felt that there was misalignment between their own development as a practitioner as a result of completing the MEd and how this was viewed by colleagues. As Natasha described, she felt that her own development as a result of completing her MEd was not recognised by others and that for some colleagues, completion of a postgraduate certificate or MEd was viewed as a relatively straightforward way of distinguishing between doctors rather than seeing the real value of such postgraduate study.

'I think it's problematic because I think I have grown as a result of my qualification. It's a bit disheartening. Basically, what they are saying is you've wasted your time. And actually, it suggests that medical educators still think that they are naturally good teachers without knowing anything about education, because they are good clinicians or good scientists. So, I think that there is still a discord with the academic pursuit of education and the delivery of education. The fact that the university still doesn't have a clearly identifiable career pathway for medical educationalists.'

Natasha went on to say,

'I recently asked someone whether they thought having a medical education qualification was worth it and they said no. That's a fairly senior clinical teacher. I think it's an easy way to discriminate between people on paper. And in our hyper competitive community where everything counts and discriminatory factors do count, there are lots of, not necessarily naturally good teachers who are applying for them (postgraduate education courses).'

As a result of this view, some doctors may be encouraged or feel pressurised to complete a MEd in order to distinguish themselves from others, particularly when applying for jobs or fellowships. Despite Natasha saying that she thought the MEd had a positive impact on her development as a teacher, she also thought that,

'conversely if you're already a good teacher, I'm not convinced of the evidence, there probably is some evidence that I just don't know about it, that actually having a formal education qualification makes you a better teacher.'

There is evidence to suggest that completion of a teaching qualification leads to better teaching and learning (Gibbs and Coffey, 2004) but Natasha's view that not everyone who completes a PGCert or MEd graduates as a good or better teacher, may be problematic in terms of the credibility of such courses and therefore in improving the status of education.

Impact on educational practice

Despite this validation of the MEd not being universal, most participants discussed a shift in their beliefs about teaching and learning as a result of studying for their MEd. It was clear from their responses that there was not necessarily a shared way of teaching within their medical communities and that participants' shift in their approach to teaching and learning may be at odds with colleagues who had not undertaken postgraduate study in education. For most participants, this shift in teaching beliefs meant a move from teacher centred, didactic approaches, to utilising more student-centred approaches. John described how before undertaking his MEd, he *'used to think that teaching was best done in a didactic way'*, explaining that he favoured *'the model of learning massive volumes of information'* whereas now he adopted a more facilitative and student-centred approach. For Clare, the

focus of her Master's dissertation (how junior doctors learnt in clinical settings) impacted on the way that she supervised them.

'Like not telling them what to do, but asking why do you think you're doing that? And what's your...reasons behind in? So, I definitely have changed how I'm supervising more junior doctors since I've done those interviews. Because I realise that I probably wasn't always doing it the way they said was most useful.'

Jackie expressed a similar sentiment about her approach to supervising trainee doctors.

'And then doing the Master's influenced me, one of the big changes it got me thinking about was how to make this much more trainee led. So how to let them take responsibility for their own training and when you do appraisals with them, to allow them to take you through their ePortfolios and...to try and help them become much more independent as learners.'

Neil also referred to taking a more student-centred approach and described the importance of taking account of students' previous knowledge and experience, and that,

'you have to create the possibility at least that people are constructing learning based on what they know already and if they don't know enough already then they're not going to learn anything at all. So, I'm much conscious of that.'

Some participants acknowledged that they had become more concerned with the broader aspects of education as a result of their Master's course. For example, Natasha, whilst acknowledging that *'I now know what a learning objective is'*, she thought that she was also more concerned about *'the overall development, identity development and...growth'* of her students. Although she did not think that the Master's had significantly changed her practice, *'I'm much more reflective of it (her practice), much more aware of what I am doing.'*

Lack of trajectories and non-participation

When discussing motivations for studying for a MEd, several participants referred to a desire to become more involved in education and to have this make up a greater part of their professional role. However, for some participants this post MEd engagement with education was challenging, with a lack of clear pathways through to the centre of the community of practice of education. For example, some participants highlighted colleagues in senior roles within medical schools or postgraduate training who did not have educational qualifications. This appeared to have an impact on the career progression of some participants those who had expertise and qualifications in education but who had not reached the same level in terms of their clinical skills or research profile. For example, Hema described at some length how she was yet to complete her clinical training and how

this presented a difficulty for her as she felt that should was unable to make the most of her educational qualifications and experience until she was a consultant. However, she was somewhat reluctant to pursue this training path as it would take a minimum of three years and would likely involve relocation.

'I think the problem I have seen is all the educators have a clinical role, so when it comes to education it is not defined by how experienced or qualified in education, they will be judged by their clinical experience...I was speaking to a few people, and they said you have two options. Pull out and go and complete your training and then you can be, can have proper value to all the educational stuff you have done, otherwise you will all the time be devalued. You know into gaining a proper post. And someone said do GP, it's only three years..... I really don't know because it's not something I wanted to do.'

However, having her Master's qualification also mitigated this to a certain extent.

'So, somebody from, I can't remember, I think (names another medical school), he was saying if you come to me, I would be happy to give you a head of something, I can't remember, feedback or something, but then he was thinking if I have somebody with a qualified, like completed training then I will have to weigh that up. But he has already done his Master's so he said I value you that and because of that I am swayed towards you. So that is something nice.'

Therefore, within this education community of practice, clinical expertise and completion of clinical training was seen as key by some participants, whether they agreed with this or not. John had similar views about the need to complete his clinical training stating that, *'I need to be a consultant before I can progress. It seems to me, before I can progress as an educator.'*

However, despite this he also felt that this lack of career path and structure provided opportunity for more creativity within educational roles.

'My plan is to get a CCT (Certificate of Completion of Training) to keep my, you know, finger in the pie here, as it were...It's not a career path as such, but I see how it (education) can be part of my career. So, there isn't, there isn't a training programme in it (education). And if there isn't a, uh, you know, there isn't an overall education body, but I, I quite like that. I probably... Maybe in 20 years, or even ten years, there will be. But I'd rather be here and now, sort of, making it up a little bit and feeling out how it's going...It feels like there's a little bit more potential and opportunity.... whereas, when it's, when it's formalised, it, sort of, it... There's advantages to it, but there's disadvantages in that, sort of, it stifles a bit of creativity and a bit of imagination. And, and stops people going off in, in, on weird tangents.... which can be quite fruitful.'

However, Hema felt that as medical education was a developing area it may well change in the future.

'Some people are still.... appreciative of the education qualifications and other educational stuff. So, I think it's quite, maybe it's a developing field.'

Helena also described the lack of career structure and progression within a medical education community of practice as potentially problematic.

'There isn't this automatic (structure)... Like if you were doing a science master's, then you'd go off, wouldn't you? And then you'd probably do a PhD and then you'd do a postdoc or... There isn't that structure...there isn't that community to step into... There's nobody to kind of write papers with. There's nobody to join in their research group with them.'

She did however acknowledge that there were now more career opportunities for those with an interest in medical education such as teaching fellow roles.

'Because I think you know, it's (medical education) an emerging speciality. And I think it's amazing the way now like we have all these young teaching fellows. Teaching fellows who really want to do this, and they see it (education) as a career option, which it never used to be.'

Despite the increase in such roles there appeared to be a lack of further career progression for those working within them, as Helena went on to explain,

'The teaching fellows are here for two years, start projects, and then just leave. There's nowhere for them to go. There's no sort of continuing development for them.'

Reflecting on her own experience, Helena described how,

'I've had to be quite creative to create my own role for continuing development...I've had to put a lot of energy into it that.'

Hema also lamented the lack of career structure for those wanting to pursue a career in medical education, explaining that,

'I have done the MEd and I still can't find you know, where to navigate through this kind of, you know pathway. And I can't see at the end, what it's going to be. So, I think it (is) a bit challenging...'

However, she had found that attending medical education conferences helped her to engage with likeminded individuals and provided her with validation that there were others who were doing similar professional work, and this supported her development as an educator.

'Say for example if I talk about research or something like social constructivism and everyone is like, oh what's that? You probably have to define what it is, before you even think about... But when I go to these conferences it's like, oh yeah, they talk about it and I can understand. And Sally (a junior colleague) said, 'oh god knows what they are talking about', and I said, 'oh I can understand that!' So, it's more like... I don't know...maybe talking kind of the same language, similar interests, like what they can do next, you know.'

Here, Hema identified the shared repertoire and language that she was now able to recognise and understand, which made her feel more part of the community.

These findings suggest that a lack of clear trajectory towards the centre of an educational community of practice was clearly problematic for some participants. Clinical expertise and completion of clinical training was still viewed as necessary to pursue an educational pathway. However, the lack of clear pathway was seen as positive by some participants in that they could construct their own role and career trajectory.

Doctor and Educator Identities

A further factor that appeared to impact on how easily participants crossed the boundaries between education and medicine was how integrated their doctor and educator identities were. The literature on medical educators' professional identities suggests some differing points of view regarding how integrated, or not, doctors' educator identities are. For example, Starr et al (2003) suggested that,

'physicians who think of themselves as teachers are more likely to enjoy teaching, to teach more, and to be identified by students and other faculty members as good teachers.'
(p.820)

However, Stoddard (2016) suggested a dual identity of clinician-educators where the two aspects of this professional role appear to be more separate. Therefore, I was interested in exploring how different participants conceptualised their doctor identity and their educator identity and how congruent or not these two parts of their professional identity were. From the interviews it was clear that some participants thought of their educator and doctor identities as very closely entwined, whilst for others these were very separate. In order to explore this congruence further I will use examples from the participants to illustrate these similarities and differences. The first three examples, Natasha, Neil and Niamh are examples where the different aspects of their identity were more closely aligned. For Natasha, her educator identity and role was very close to her identity as a doctor and academic, whilst Neil went further and spoke of how he thought one of the distinguishing factors between humans and animals was that humans taught others. However, in the second set of examples, Ben and Hema, the distinction between their role as an educator and their role as a doctor was more distant.

For Natasha, Neil and Niamh, their educator identity appeared to be very much part of their doctor professional identity. For example, Natasha gave an example of congruent doctor and educator identities explaining how she thought that all doctors were teachers and referred to the,

'bread and butter teaching role that all doctors have by virtue of the fact that they're doctors, because you are always, well first of all there is the teaching element to talking to your patients. Take that aside, it's part of the culture of medicine to always be teaching the juniors that we are with so there is that sort of bread and butter aspect to it.'

As well as being important for those working in clinical contexts she also thought *'that it is important, incumbent upon all academics to be teachers'*. These quotes clearly express Natasha's expectation that all doctors working in both clinical and non-clinical settings were teachers, although her use of the term *'bread and butter'* suggests perhaps a taken for granted or undervalued aspect of teaching. Despite this, she thought that the expectation of doctors being teachers was underpinned by policy.

'... it's definitely a view that the General Medical Council and BMA hold.... when I signed to say I had finished my training it said, you know, do you abide by all the steps that it takes to be a good doctor. And actually, I realise now that with my MEd hat on, part of the job description of a good doctor is to be a good teacher.'

However, she did not think that medical students were necessarily aware that this was a key aspect of the role of the doctor.

'What I find interesting is something that isn't hammered home at medical school. Maybe more now than it was in my day but I didn't come out of medical school thinking I was a teacher but I certainly came to the end of my training thinking that it was a very important element of my job. And actually, if you think about the way we communicate with patients and public health issues, a lot of that is about education and certainly within the hospital environment where there is a constant stream of medical students and or junior it is a natural part of what you do.'

Neil went further and described how teaching was not only part of his job as a doctor but part of all human beings *'whether they knew it or not'*. He also described how the MEd had impacted on himself beyond his role professional role as a teacher, referring to how he now thought about his own children's education.

'Their education is of great, great importance to me as it was to my father and so actually, probably one of the most beneficial parts of having thought about teaching, having done the Master's was that my children have been beneficiaries. I encourage them to learn in a way that I wouldn't have done before in terms of constructing their own knowledge and that kind of thing. Actually, as time goes on I see myself as more and more... maybe it's how I see human beings. Maybe human beings are fundamentally a teaching animal.'

Niamh described how one of the benefits of completing her MEd was that she felt part of a wider community of educators.

'I suppose the thing that I found the most, one of the most valuable things about the course, (is the) interaction with other educators through that and wider than that, is just seeing the connections really between what we do in medicine and what we do in other areas of the university life and how much there is to be gained from that really. And to feel part of the

community of educators. You know, I do see the connection now a lot more between myself and nursery teachers and you know, there's not that much difference (laughs).'

For these participants, crossing between the communities of education and their medical specialty may have been easier because of the more congruent nature of these two aspects of their identity, or that they had been able to reconcile these differences. In contrast, Hema and Ben's experiences suggested greater separation between their doctor and educator role and identity. For Hema, her educator identity appeared to be more central, partly because of the number of days she worked in education (4 days) compared with clinical work (1 day). She also described how when she worked clinically she found it difficult to integrate herself into this team because of the fragmented nature of this work and regular changes in staffing.

'What I find hard with the clinical side, especially with these days all the time the doctors change, I'm almost like a visitor there. Every time I go there is a new set of new people and I have to introduce myself and by the time you build a relationship or rapport its time, they have already moved. So, I find it a little bit sort of, even though I go every week to this particular ward, it's like some kind of a visitor.'

This quote suggests that Hema was more on the periphery of this community of practice and because of the lack of stability, found it challenging to move towards a more central position. She also did no teaching in this clinical setting despite having relative expertise in teaching compared to her clinical colleagues, suggesting perhaps that this type of activity was not as valued within this community, even though it was likely that her teaching of medical students and others was taking place in this context. Hema also questioned her own identity as a doctor saying,

'Probably my main commitment (is) to teaching because sometimes I was thinking, am I more a doctor now or a teacher? Because I do very little clinical (work), and then lots of teaching.'

Ben's responses also suggested that there was some separation between his educational role and surgical role. However, this was not as in such stark contrast to Hema and these differences changed depending on the role or context with education coming more to the forefront, or more in the background depending on current priorities.

'When I'm asked what my job title is, I say, I am a surgical trainee. I don't say, I am an educator...But, I do the education as part of that, so it kind of bolts on. It's not a standalone thing for me. Even though I do it a lot, maybe I don't highlight that enough, but it just kind of goes along the background. It's a module of the things that I'm involved in, and a lot of people are involved in. But unless you take time out to do a formal teaching fellowship where you spend some time just doing that every day, it's always gonna be somewhat second fiddle to the other things that you do.'

Here, Ben articulates how his differing professional identities work with each other suggesting that his surgeon identity is at the forefront, with his educator identity as part of this. For Hema, her teacher identity appeared to be the greater part of her professional identity, perhaps as Ben suggested in his quote, because she was working for most of the week in a teacher fellow role. For Ben, it appeared that his educator identity was one of multiple professional identities that he had alongside his identity as a surgeon and a researcher and his educator identity was not his primary identity. Even though these participants were involved in teaching and had all completed their Master's in Education, it appeared that there were differences in how much their educator made up their professional identity. For Natasha, Neil and Niamh, it was a key part of being a doctor, whilst for Hema and Ben these identities appeared to be much more separate.

Summary

For many participants the transition to a new community of practice (education) was challenging because of different views and approaches. Challenges of engaging with education included learning a new language, differing views of education, conducting research within a new paradigm, and navigating their desired trajectory within an educational community. This appeared to be more problematic for those wishing to be more involved in education and despite their educational qualifications, a limiting factor was a lack of clinical qualifications. The positive impact of completing a MEd included improvements in teaching practice and validation, both for the institution and for participants themselves as educators. The overlapping nature of participants' doctor and educator identities also varied with some being much more intertwined and others more separate.

The following section considers the key theme of status and prestige in education, how participants experienced this and how this impacted on the way they engaged with education and thus developed their identity as an educator.

4.5 Status and Prestige of Education

The previous sections discussed the different communities of practice that exist within medicine and education and some of the factors that impacted on the participants' ease or difficulty to cross these boundaries. As described in the literature review, boundary crossing is type of trajectory that is particularly challenging where two communities of

practice have different practices, repertoires and types of engagement. Therefore, one factor that appeared in the data to impact on the ease or difficulty of boundary crossing for participants was the relative status of education and how this was viewed by the participant as well as those around them. A criticism of Wenger's early work was that the significance of power relations was somewhat marginalised in the application of their theory and there was a failure to consider wider institutional contexts within which boundary crossing takes place (Contu and Wilmott, 2003, Roberts, 2006, Kerno, 2008). However, this was more significantly considered in Wenger's later work in which he argued that there is complexity in practising across communities and that this complexity is often rooted within a political dynamic (Wenger-Trayner and Wenger-Trayner, 2015). That is, different communities of practice impact on the broader landscape through their discourses and what they hold to be valuable. In the case of medicine and education, the previous literature suggests that there is a difference in the status of teaching when compared with other practices such as clinical skills and research that the participants are likely to also be involved in.

Therefore, this section explores how the relative status and prestige of education appeared to impact on participants' identity. Some participants discussed how they thought education had a lower status, supporting previous findings on this (Coate and Kandiko-Howson, 2016). However, several participants gave examples of how they thought this was changing and the status of education was already high in some contexts or increasing in others.

In discussing the relative status of teaching and education, many participants' views concurred with findings in the previous literature (e.g. Bartle and Thistlethwaite, 2014) in that they could provide examples of how they thought that the status of education was lower in comparison to the other aspects their roles and practice. Examples of this included a lack of time and money to engage with educational activities and, as was borne out in my Institution Focussed Study (IFS), a sense that doctors were only involved in education because they lacked clinical skill or ability. However, many responses revealed more complexity than a simple dichotomy of teaching having low status and research and/or clinical skills having high status. For example, some participants distinguished between how *they* saw education as having relatively high status or importance and the view of colleagues that education had a relatively low status. Indeed, as previously discussed, several participants described the validation for their role and identity as an educator that

they gained through completing their Master's in Education. Other participants described how they thought that the relative status of education differed depending on the context or situation. Furthermore, there were some differences in how participants felt about, and experienced, these differences with some reporting little or no tensions, even when education was reported as having a lower status. Identity capital may be one way in which participants managed the tension of engaging with education that risks being viewed as low status by colleagues and this will be discussed in further detail.

Education as a lower status activity

Several participants clearly and quickly identified with the idea of education being a lower status activity in comparison to research and/or clinical skills. John was adamant that whilst he regarded education and his involvement in education highly, it was not so for his surgical colleagues. Sabrina also thought that there was a prevailing view within surgery that,

'They (surgeons who educate) are not good enough surgeons or they are approaching their retirement.'

When compared with research, Ali thought that,

'there is a sort of almost unspoken undercurrent to some of the consultants thinking it (education) is not as highbrow.'

As well as a perception that educational activities were viewed as lower status, some of the participants provided examples of how this perception played out in reality. Neil provided the example of his annual appraisal in which the appraiser would appear to be only interested in how much research grant income he had generated or the number of research papers he had published, and be quite dismissive of the educational activities he had been involved in. He described this meeting by referring to,

'...the kind of rough time that your boss will give you at your annual appraisal, you know, big grants and a paper in Nature, no one's going to get into how much teaching you've done.'

Ben also acknowledged that he thought education had a lower status and provided the example from his own institution where,

'some people who are very involved in education are given a certain title compared to people who are involved to an equal level in research.'

The implication being that this title identified those whose role was primarily in education as different to other academics. A further example of how this relative difference in status

played out was from Clare's interview. She described how in her latest ARCP (Annual Review of Competence Progression) meeting she was told that she needed to do additional audits because she had been completing her Master's in Education.

'Because one of my supervisors at a recent ARCP (Annual Review of Competency Progression) was sort of saying, have you made sure you're doing other things as well as just medical education.... But to make up for it (studying for her Master's in Education), I've had to do two audits a year, instead of just one...Writing a presentation on intensive care at a conference instead of teaching. So, I think I definitely have to make sure, at my level...that it's not become the only thing that I'm doing...because it's a little bit too early, in terms of, certainly how my ARCP panel view it.'

As well as discussing the relative lower status of education, some participants put forward suggestions for why they thought this was the case. Often this was due to a lack of time and increased service pressures, as Jackie described,

'I can think of weeks where there is so much going on... and you get to the end of the clinic and you just look at your registrar and think, well we've seen everybody and got everybody sorted. You and I have not had a conversation about anything, I have not taught you anything, but the reality is that was what clinic was like today.'

Rohan also commented that whilst he thought that teaching was appreciated by medical students and trainees,

'when I think about my managers...I don't think it's appreciated by them at all. In a sense, they just see it as slowing down the service.'

In contrast, Ali described working in a department where time was set aside for education *'regardless of what is happening on the unit.'* He went on to provide the following example of a weekly teaching session that had become embedded within the culture of the department.

'Like on a Thursday, there will be a simulation...And I get the sense that probably over the last five or six years, before I even started, that they had to introduce it and then get everyone to buy into it...So I think it's become embedded into the running of the unit... Definitely the culture is one of, education being mostly valued. Rather than being something that happens on the side or if it's quiet, or, you know, rarely.'

However, Ali also reflected that he had worked in some places where undertaking educational activities was more challenging - *'I've worked in places where you struggle...you don't get any time to do it (education).'* Therefore, a lack of time was clearly linked to the importance of educational activities and that without dedicated time these activities often did not take place. As well as a lack of time within the workplace, Natasha thought that the relative status of education was linked to the lack of space within the undergraduate curriculum dedicated to education, stating that she did not recall ever being taught about

education and teaching as part of her undergraduate studies. Natasha went on to suggest that if education was part of the postgraduate examinations that trainee doctors needed to complete and if there was more financial support for undertaking educational courses then its status would increase.

'And there was one (a Master's in Education course) at the royal college which I looked at fleetingly but it cost such a ridiculous amount of money I just thought that's not worth it. So, subsidising it makes a massive difference. So, if we are really serious about it why doesn't MRCP (membership of the Royal College of Physicians examination) have an element about medical education...? If the GMC wants us to identify, not just identify but to be teachers as part of our job description then we should be examined on it in the way that are clinical skills are.'

Judith also thought that the status of education was not helped by the fact that lip service was sometimes paid to developing oneself as an educator, suggesting that,

'if you just go to the course (teaching course) so you can continue as you did, which is what I think a lot of people might be doing, we're not going to get that improvement in social standing as educators we might want.'

Perhaps paradoxically, Ali thought that the status of education was linked to the fact that all doctors were required to teach.

'...it's kind of just assumed as a doctor, that the senior doctors will educate, but aren't necessarily always that keen on it.'

He compared this situation to what he observed in nursing education, stating that,

'I think, certainly for the nurses, if you've doing a lot of teaching...as in if they see me doing lots of teaching, or other people doing lots of teaching, then they hold that in quite high regard. Because they, you know, see it as a very positive thing.'

Ali also reflected on the fact that within nursing education, some nurses hold a specific role or post as a nurse educator, someone for whom education *'is their job essentially.'* Judith also thought that the status of education was lower because,

'everyone believes they're an educator and the people who really go for education end up doing less research or clinics, (they) quite often will do less complicated clinical stuff. So, they are lesser beings on that front I suspect.'

Therefore, because the GMC requires all doctors to be involved in the teaching and education of others this appears to have the opposite effect of elevating the status of medical education. Those who choose to specialise in medical education are perhaps seen as specialising in a discipline and practice that all doctors should engage with anyway. Consequently, those who then choose to pursue medical education as a specialism are

considered, in the experience of some participants, to not be proficient in clinical skills and those who have clinical and/or research expertise will be required to teach anyway.

The changing status of education

Some participants felt that, although education had previously had a relatively low status, this perception was changing and that this change was often linked to the money that came with educational activities. For example, Louise commented that colleagues were *'starting to realise that there is a lot of money in education for the hospitals'*. Niamh also commented on the impact that finances had on the status of education explaining that,

'...traditionally it's (education) had a lower status...I mean I think it's been a bolt on really...But I don't think it's quite been viewed in the same way now.... One element that is supporting the fact that it's not seen in quite the same way is basically money. Like many things in life, follow the money... and there's lots of money in education.'

Neil referred to changing status of education as a result of increased financial benefit from teaching activities and that this would then be linked to teaching qualifications.

'Everyone's being saying any moment now teaching is going to be widely accepted as important and I think... because of the financial side I think the truth is that it is starting to come through and if it does become a requirement that teachers have to be, have a qualification sometime, for sure, I can see the (institution) pushing it very hard because it does.'

This increase in financial income from education appeared to directly impact on the prestige that it was afforded. Furthermore, Louise also felt that,

'people are just starting to grasp the idea that good education helps. Like it helps the patients, it helps the team work together.'

Sabrina also referred to patient care as a driver for change within medical education.

'Yeah, I think the need to communicate well with patients. That's very hard to learn but it's required.... So, yeah. I think everyone sees that over the last couple of decades medical school has changed a lot and we need a different approach to patients and that can only be done by changing the curriculum.'

Therefore, according to participants' experiences, the status of education appeared to be growing, partly because of an increase in money, or an increase in the awareness of the money that education brings, and partly because of other external factors such as patient care and the introduction of higher education wide policies such as the Teaching Excellence Framework (Department for Business, Innovation and Skills, 2016).

Different status in different contexts

For some participants the differences in status between the various aspects of their professional practice were more nuanced than whether education had purely a higher or lower status compared to research and clinical practice. Natasha, for example, suggested that there was a difference in status between clinicians who educated and academics who educated. She suggested that for some clinicians, education had a very high status and that for those '*clinicians who are externally regarded as great teachers*', their role and practice as a teacher '*augments their prestige*.' She elaborated on this by saying,

'So, I think that if you've got a NHS doctor who is considered a great teacher ...he or she would likely be in a teaching hospital which is considered more prestigious, and they would, by virtue of the fact that medical students love specialists...they would probably be a specialist and... I can see how that would feed into their overall ranking and external appeal.'

In contrast, within academia Natasha thought that education had a '*lowly status*' compared to research and that those who were engaged in high end, cutting edge research were '*shielded*' from educational activities. She attributed this partly to the pressure to produce research outputs.

'Amongst academics, I still think that's it generally held that people who are doing super, super high-end science, may have a lot to say about curriculum content etc. and they may increase the pull of a universities because students want to learn at a university where that kind of science is happening. But in reality, these people are shielded from the relatively lowly.... The lowly activity of teaching and it's given to the minions.... But I think that as you become ensconced in the pressures of academic output and the pressures of producing research outputs and you get a bit older and a bit more distance from the front line, I think that's probably the first thing that goes.'

As mentioned previously in discussing the lack of trajectory to the centre of an education community, Helena suggested that there was a disconnect between those involved in researching medical education or who had undertaken qualifications in this area, and the senior leaders of the medical school. She described what she thought was a '*big divide*' between these two groups of people, stating that,

'I still see this big divide between often the people who are doing the research or the people who are running the medical school. And there's some people who are doing both, but often even the ideas are widely different. And I appreciate that the kind of the, like you said, the utilitarian point of view. There has to be practical aspects to running a medical school. It's hard work, and a lot of it's practical, and you know... But again, the sort of the whole ideas have not necessarily filtered through, and some of the ideas are so esoteric, how do you filter it through to sort of more practical aspects...'

As well as this divide she also thought that there was a difference in status with *'the sort of high-status people at the medical school who run exams'* and that in some cases they held *'quite different views'* to what she had been taught on her Master's course. She went on to say,

'so, a lot of people don't have necessarily medical education qualifications. Not that they aren't enthusiastic and put a huge amount of time and energy into it. They do very much so, but it's perhaps a different community practice than you wanted to join. So, there's all those sorts of tensions.'

Rohan also described an incident where he felt that his MEd qualification, hindered his chances of gaining a job.

'In one job I went for after I had just finished the MEd, the fact that I had done this qualification was seen to lose me the job.... I think some of the doctors there who had university roles felt actively threatened. I've never come across it since... but the extra qualifications seemed to go against me. For future jobs, I played it down for fear that the same thing might happen.'

As well as differences within medical education generally, there also appeared to be different views regarding the status of education depending on the specialty that the participant was working in. Justin described how he thought that there were lots of common elements between education and psychiatry, for example motivation to help people grow and develop. Therefore, within psychiatry, being involved in education was viewed positively. Helena, a General Practitioner (GP), described how for her, her educational role had relatively high status. This was because she did more educational than clinical work and that working within a medical school could be a *'very positive thing'* because of the larger team and clearer, more defined, career structure. However, she distinguished between herself and a GP who was a partner at a GP practice and who may therefore view education differently because *'their practice...has to be their priority'*. In contrast all the surgeons in this study (Sabrina, Ben and John) commented on how education was seen as a low status activity.

Identity capital

As discussed in the literature review, the concept of identity capital might appear to play a part in how individuals defend their role and practice within education. Whilst it might appear that differences in status and prestige of different activities would likely cause tension, not all participants appeared to experience difficulties with trying to manage the different aspects of their work (research, clinical practice, and teaching) and the relative status that they each held. One explanation would be that, had they felt tensions, some

participants may not have felt comfortable in sharing this with me. Another possible explanation is that those participants who did not reveal tensions did not experience these as such, because of the amount of identity capital that they held. For example, Neil and Ben, both of whom seemed unconcerned by the relatively low status of education, had well developed research careers (in one case a high profile one) and, as both were working at top London hospitals, I assumed had well developed and highly skilled clinical practice. One explanation would be that this perhaps made it easier to be involved in education and that they were more immune to the challenge from others of only being involved in education because they were unable to do other things (a finding borne out from my IFS). Furthermore, the age of the participant or how well established they were in their career may have played a part. Participants who were more junior in their career, for example Clare, who was the most junior of all the participants, appeared more concerned about the relative status of education and how this was seen by their colleagues, particularly those who were more senior. Those participants who were more senior and established in their careers, whilst acknowledging that education may have a lower status than other aspects of their professional role, appeared less concerned by this and provided fewer examples of how this tension played out in their own experience.

Summary

This section has considered some of the challenges of boundary crossing in relation to the status of education when compared to other aspects of participants' practice such as research and clinical skills. Whilst in many participants' experience, education was considered to have a lower status this was not the same for all. Some participants felt that the status of education was changing, largely due to the money associated that came with educational provision but also because of an increased emphasis on using education to improve patient care. Other participants felt that the context impacted on how education was viewed, with education in some settings, for example within a teaching hospital, being more highly regarded. Some participants appeared to be able to draw upon identity capital to mitigate the impact of their educational practice when perceived as low status. The following section expands on some of these issues through the lens of gender.

4.6 Gender differences in identity development of medical educators

The previous sections have considered the interplay between participants' role as a doctor, their medical specialty, and their educational activities. The findings in these sections support the view that education and medicine are not single communities of practice, but

rather multiple communities that participants might engage with differently at different times. This potentially makes boundary crossing between these communities of practice a challenging endeavour, as it is dependent on the nature of both medical and educational practices that participants engage with. This could be further complicated by the status of various educational activities and the amount of identity capital that participants hold to mitigate against the low status of some educational activities in some contexts. A further complexity which may impact on how participants engage with an educational community of practice, and is potentially linked to the status of these activities, is the gender of the participant. As discussed in the literature review, Wenger does not address factors such as gender when considering how individuals may engage in a community of practice (Paechter, 2003b). However, it may be particularly pertinent to consider the impact of gender on medical education practices because of the changes in male/female demographics within the medical profession in recent years.

Furthermore, gender may be an important factor to consider in terms of the status and hierarchy of medical education. As Bleakley (2013) argues, despite the increase in the number of female doctors this is unlikely to have significant impact on practices within medical education until there are wholesale structural changes. Therefore, exploring the issues of gender, status and hierarchy within the participants' interviews may shed light on these differing structural practices. In addition, although there is a significant amount of literature that considers gender differences in teacher beliefs and practices, there is little that considers possible differences in the experiences of those working within medical education and particularly those who have completed a Master's degree in this discipline. Therefore, given these factors, I was interested in exploring the interplay between gender, engagement within an educational community of practice and the status of this practice, and how these factors framed the experiences of both male and female participants. This was explored with participants by asking if they thought there were differences between males and females and how they engaged with education. This section considers how gender influences the professional identity development of the participants in this study as a manifestation of some of the issues of status explored in the previous section. I begin by acknowledging how gender has been problematised and by considering the ways in which participants responded to this question in the interview. This section then goes on to consider gendered approaches to educational activities, gender and the status of education, and gendered approaches to career choices in medical education.

The problematisation of gender

Before discussing the themes from participants' responses about gender and medical education, it is worth acknowledging that gender is a contested term. As outlined in the literature review, several authors have problematised the concept of gender and have argued that the terms '*masculine*' and '*feminine*' are fluid and cover a range of concepts. However, whilst I recognise the multiplicity of these terms, I have used the terms '*gender*', '*male*' and '*female*' in both the interview and the write up of this chapter. Given previous research (e.g. Verdonk et al, 2007) suggesting doctors lacked awareness of the impact of gender on their practice, it was reasonable to assume that participants would have better understood these terms rather than the notion of multiple and shifting masculinities and femininities. Furthermore, as Ramazanoglu and Holland (2002) suggest, the term gender can be taken to include,

'sexuality and reproduction, sexual difference, embodiment, the social constitution of male, female, intersexual, other; masculinity and femininity; ideas, discourses, practices, subjectivities and social relationships' (p.5),

and I therefore left it up to the participants to interpret these terms how they wanted and to recount any experiences that they thought were relevant. As a result, the concept of gender in this chapter is taken to mean a range of things depending on how participants wanted to view this.

As will be discussed further, many of the participants appeared unaware of how their and others' gender may have impacted on their practice and this therefore appeared to be an unexamined part of their professional identity.

How participants responded to questions about gender

Before considering *what* participants said about gendered educational practices, there were some observations about *how* they responded to this question that may be usefully considered in order to put their responses into context. Approximately one third of participants thought that there were differences between male and female doctors and their engagement with education. Typically these were reported as males being more didactic in their teaching and females being more nurturing. Furthermore, participants could provide examples of these differences from their own experiences and practice. The remaining two thirds of participants did not identify any gender differences, although some did attribute differences in approaches to teaching and education to factors such as specialty, previous educational experiences or personality differences. Where gender

differences were identified, these were commented on by females more than males and also done so in a more extensive way. In addition, some of these comments about differences in gender came about during other parts of the interview. For example, when both Hema and Sabrina were discussing the challenges of combining clinical training with family life and thus educational roles appearing more attractive to them, this was not in response to my specific question about gender. This suggests that for these participants, issues of gender were of particular importance to them. In contrast, when I did ask a specific question about gender differences in medical education, it appeared that many of the participants had not previously considered this as an issue. For example, they paused before answering, commented that it was an interesting question, or more overtly said that they had not thought about this before. This was demonstrated in Justin's initial response to this question.

'Um.... it's (gender differences) not something that has ever come to mind before and now I'm being asked it it's not something that I see any differences particularly.... No, and again I don't know....so, so no (laughs)'

Also, when participants did respond to this question, most participants talked about the gender of other colleagues rather than their own gender and how this might impact on their professional practice. This supports Tsouroufli's (2016) concept of the '*gender-neutral professional*' (p.3) whereby characteristics of an individual such as gender should not impact on their professional clinical practice and therefore this idea could be applied to a medical education context. However, I did not directly ask participants whether they thought their own gender impacted on their professional practice or experience as I felt that this was too direct and possibly intrusive, particularly given that issues of gender were not something that many participants had previously considered. Furthermore, some participants commented that their colleagues were either all, or predominantly, male or female and therefore they were not able to make an observation about gender differences. For example, Neil stated that all his colleagues were male and that he did not see them teach and so he was not able to comment on any gender differences. Clare also commented that she did not think that there were any gender differences, despite estimating that about 80% of those involved in medical education, from her previous teaching fellow colleagues to the head of a medical school, were female. Again, this gender imbalance was not commented on and she thought that any differences she had observed were due to age and seniority (factors which will be discussed in more detail later in this chapter).

'I didn't really encounter them very much (senior men in the medical school). They'd sometimes send slightly abrasive emails about OSCE (objective structured clinical examination) stations.... But I think that was probably because they weren't just men, they were, like, older, fairly senior...in the medical school.'

In both these cases the participants did not provide any suggestions about this gendered make up either in relation to a specific specialty or medical education more broadly. This is not intended to be a criticism but rather an observation and suggests that issues around gender may not have been of importance to some participants. These observations mirror Verdonk et al's (2007) view that doctors do not appear to be aware of the impact of gender on medical education and that where there was awareness, this was more common amongst females than males. A notable exception was Rohan, who recognised that surgery was male dominated but that there were increasing numbers of female surgical trainees joining. He also commented that on a teaching course he was involved in there were no female faculty members and he actively sought to correct this.

Having considered how participants responded to this question about gender, the subsequent section considers some of the gender differences highlighted by participants. These related to three main differences; differences related to approaches to educational activities, how these differences were linked to status and prestige, and actively choosing a role within medical education because it was more compatible with family life. Each of these will be discussed in further detail, as well as some of the alternative reasons put forward by participants for differences that they observed within medical education.

Gendered approaches to educational activities

In relation to approaches taken to educational activities, John thought that males took a more positivist approach to their view of education and were more likely to be involved in didactic teaching. In contrast, he thought that females were more open to new ideas and he thought that they found the transition across boundaries from medicine to the new discipline of education easier. Ali also thought that females took a more nurturing approach to their education role, referring to more females being involved in education because it,

'would be seen as, sort of, almost maternal...the mother figure on the unit, teaching everyone what is going on.'

This supports previous literature such as Mariskind (2014) on the caring role adopted by female teachers in higher education. Ali then went on to compare a female and a male colleague and their approaches to education.

'Certainly in our unit, it's the female consultant that's the head of all the education. And it was a male consultant that was the one that was saying the problem with education is left to the educators.'

He also thought that males and females differed in their teaching styles suggesting that,

'for the most part the male consultants are more of the, go and learn this fact. And...if you don't know this fact, I'm going to mock you until you do.'

In contrast to this he described the female consultants as taking *'more of a, kind of collaborative approach.'* Despite reporting these differences, both John and Ali also commented that there were no gender differences in the make-up of their MEd cohorts, with their groups being approximately 50% female and 50% male. Therefore, these observed differences in teaching practice did not appear to impact on the number of males and females who chose to study a Master's level qualification in education. However, Sabrina reported that in her experience more of her female colleagues were involved in education than male.

'When I think of it the only male who is involved in medical education is this professor that I was talking about, who is a professor in surgical education. The rest is all female. So there might be differences in interests, probably...But I don't know if that's really because of an interest or feeling responsible for the students. That is a gender difference I think. I don't know where it comes from actually.'

Some participants described differences in the presenting styles of males and females, with Judith explaining that she thought males were more confident when teaching generally, and specifically when presenting research. She gave the example of observing trainee doctors giving lectures and commented that although she thought both males and females put in the same amount of work or referred to the same number of references, the males were more definite in the conclusions that they reached. Natasha also thought that there were gender differences in presentation styles. Like Judith, she thought that males were more definite in their presentation of research findings whilst females presented results in more couched terms, even though the results may be similar.

'Arguably in terms of the delivery of the lecture, I've noticed this in conference speeches as well, women will be much more nuanced and much less aggressive in their conclusions. Whereas a man will stand up there and say these are my results and this means this. And not bring into the fact that there is some uncertainty, he will be just as aware of it as the woman, but he won't make it obvious...'

She thought that this then impacted on how well the research was received by the audience with research being presented with more certainty being thought of as *'better'* research, with *'a stronger message'*. As previous literature suggests, males appear to feel

more confident taking on the role of expert (Bress, 2000) and are therefore more likely to take on that position. Natasha also suggested that the audience were at fault in terms of how they responded differently to presentations from females and males.

'I also think that there is also an element of sexism amongst the audience. So, I'm willing to bet that a majority of medical students listening to a lecture from a man or a woman would believe it more coming from a man. And that's true of the women in the audience as well. So, I still think that there are some deep-rooted sexist attitudes. I noticed at a recent conference, people ask the audience for questions, not a single woman comes up the microphone because asking the questions and being up on the stage is not about... asking questions, it's about stating your claim for dominancy in a field... and I also think that women naturally want to help, and multitask and enjoy being useful and don't necessarily put themselves forward for the limelight positions because that's most uncomfortable because its more aggressive.'

Here, Natasha suggests that it is females themselves who moderate their own behaviour and the behaviour of others. Natasha's comments link to Cassell's (1997) findings that it is often females themselves who monitor and enforce gender typical behaviours. As Mattsson (2015) argued, females may act in a particularly feminine, caring or diffident way to mitigate being viewed as too successful or intellectual.

Other participants reported no differences in the ways in which they thought males and females engaged with education. Where differences were identified these were often attributed to factors other than gender. For example, Jackie initially wondered *'if my male colleagues are more likely to be on the didactic side of things?'*, perhaps revealing some assumption about what her expectations were, but then went on to counter this by explaining that many of her female colleagues took a more didactic approach to teaching and supervision. As with other participants, she speculated as to whether any differences in approaches might be due more to the specialty that an individual worked in, rather than differences in gender. Louise also thought that there were no differences between male and female medical educators as this was not something that she had ever observed. She also thought that it was more to do with the specialty citing an example of paediatrics where *'everything was very nurturing'*, in comparison to other specialities she had worked in. Helena also commented on perceived differences between specialities stating that,

'...it tends to be the surgeons that you hear speaking that are more didactic in their approach towards teaching...'

Other participants such as Justin and Louise commented on the link between gender and chosen specialty as the reason for these differences. In the quote below, Justin explores

some of the overlap between his specialty of child psychiatry, the gender makeup of the professionals working within this specialty, and approaches to education.

'But I wonder if that might be or my perception might be influenced just because of the discipline I'm in. Because I don't know, in terms of what the researchers looked at, so I guess people go into psychiatry and maybe particularly child psychiatry because they want to work with people, families to help them to change and I think.... just thinking generally child psychiatry tends to be a bit more female dominated...I'm one of only two males in a team of about 20 females. So, in other words, as a discipline for whatever reason it doesn't tend to attract many males and it might, for whatever reason, and I'm just wondering if the males who do go into child psychiatry are.... you know maybe have that particular interest with maybe working with people, working with change, I guess that sort of.... are interested in systems and the bigger picture and quite into, I don't know, sort of working with the grey and uncertainty. It's not just about chopping an appendix out... and I don't know if therefore between males and females there might not be that much difference when it comes to education as opposed to, I don't know, maybe looking at surgery or even a non-medical discipline...'

Niamh was more explicit in her expectation about gender differences stating that she had expected to see females as 'more cuddly' than their male colleagues. However, she reflected on this for some time, before concluding that she had not actually observed any differences.

'You know there may well be gender differences. I mean if you look at... School teachers, there are more female school teachers than male... and it's an interesting thought and ...I don't know what they would be though... I'm not sure what they would be... I don't see a vast gender difference between them.'

Like Jackie, she speculated as to whether these differences had something to do with the specialty that individuals were working in but also that she had observed differences in teaching between doctors of different ages as well as between those who had different previous educational experience.

Some participants did not attribute differences in practice to gender, specialty or previous educational experience but rather individual differences. For example, Hema thought that differences she observed were more to do with individual personality, comparing the different clinical teaching fellows that she had worked with. In this quote she describes some of the differences and similarities between them.

'I think it depends on the personality. I was thinking about different teaching fellows that have worked with me. So last year I had two girls. They are very much, they spend good time preparing themselves. They would want to rehearse before and they would like to ask for feedback from me. And the two boys who work with me, particularly one boy, he will just, in the morning ask, 'what am I going to teach?' ... I thought is it something to do with male and female? But then I had another boy who worked with me two years ago, he was like that...he needs to know 'what am I teaching?' and he needs to be quite comfortable

with what he is planning to teach. Whereas just at the moment... I have another two flowery, I call them flowery girls, they are like that, they would just come up, and if there was a question they didn't know, they would somehow give something...'

Although there were differences between Hema's junior colleagues in how they approached their role, she ultimately attributes this to individual differences rather than gender differences. Louise also concluded that any differences in teaching style or approach were *'just to do with your personality'*.

Gender and status

Niamh was one of the few participants to consider the wider context in response to this question as she suggested that education may be considered lower status because of the number of female doctors engaging with it.

'I don't know if you are trying to connect it with the previous thought about the status of education not being as high and then if there are more women involved in education maybe that is related...'

This view supports findings by Drudy (2008) who, although writing about teaching in the compulsory education sector, highlighted the link between the feminisation of teaching as a profession and the esteem in which the professional was held. In addition to Niamh, Helena also made some links between gender and status.

'You know, we work in a very female department and I think there is probably something in that.... I don't know whether it's a kind of status thing... I think probably education is a lower status than, you know clinical medicine.... And for women, the kind of status of education is enough for them.'

Here, Helena suggests that women are less concerned about academic status although it is not clear why she thought this. It may be that she thought female medical educators have lower aspirations or, as Tsouroufli (2016) also found, issues of status and the need for approval are less relevant to them. Helena also recognised that the increase in the number of female medical students may impact on the lowering of the status of medicine overall. However, like Bleakley's (2014), Riska's (2009) and Seabrook's (2004b) views about the influence of more women in medicine, Helena did not necessarily think that this change in gender demographics was necessarily a negative outcome saying that,

'we're becoming kind of gentle, more nurturing...because it (the medical school) used to be quite a harsh place, maybe it will become a more nurturing place. Maybe that's not a bad thing.'

Here, Helena evoked the gendered practice of women being more caring but viewing it as a positive change within medical education.

In terms of different activities, Natasha thought that there was a gender divide between research and education, as well as in the types of educational tasks that males and females did. She thought that males were more likely to be involved in research, with females taking on the majority of educational roles. Within education, she also thought that administrative tasks were more likely to be done by females. In this quote, Natasha explores some of this complexity in terms of the hierarchy of activities within teaching.

'So, I think that there is a gender divide in the way that men and women teach. I also think that on occasion teaching is seen as... as the easy alternative for people who have failed at a research career, and that more often happens with women. I think that teaching is associated with a massive administrative load and I think that there may be some truth although I'm not totally sure if it's ever been audited, but it has sometimes been suggested that the administrative side of teaching is more heavily laden on women, but the superstar, standing in front of an adoring audience is more....is more male. So again, that's probably hinting that there is a hierarchy of teaching, you know, so arguably the hard hitters are looking after their PhDs students and of course there is some advantage to them to have a PhD student who is producing papers for them whereas the administrative load of being a course lead and actually delivering, which I am willing to bet is much more representative in terms of there being more women doing that.....Being lead for a year group or course director et cetera. I haven't looked up data but I am willing to bet that there are many more women doing that than there are women doing research intensive jobs, where they are not expected to do as much teaching.'

Natasha's comments reflect findings from research by Coate and Kandiko-Howson (2016) which identified female academics as engaging in more teaching than male colleagues, with teaching being perceived as a less prestigious activity than research. These comments also reflect Morley's (2003) concept of domestic labour to illustrate the type of activities that female academics are involved in. As Natasha explained, women were more likely to take on organisational and administrative tasks than their male colleagues. Therefore, not only did education in general appear to have a lower status for some of the women involved but also some activities within education.

Gendered approaches to career choices in medical education

When discussing the possibility of leaving her full time teaching fellow role in order to complete her clinical training, Hema considered the impact that this might have on her children and family life.

'I would love to (complete clinical training). The only problem is.... I feel like I have lost a lot of time to go back and do my training. And I think it's hard to, because of my family as well,

I think that is one reason I felt quite comfortable staying in one place, not doing night shifts and stuff like that. And I'm not the kind of person who can live away from the family and I would probably be depressed and moan. So, I think I'm happy with you know, the life style. Maybe I can't ask for everything!'

In this example, pursuing a role in education meant that Hema could accommodate and manage other aspects of her life such as childcare. Educational roles did not generally involve working anti-social hours or doing nightshifts, and therefore individuals were likely to have more control over their time. Furthermore, completing clinical training would likely involve multiple changes in workplace location, which for Hema was too difficult given her family commitments. This was despite the fact that she had been advised that completing her clinical training would be beneficial to her progressing within medical education. Here, Hema felt that she was prevented from career progression firstly, because of the need to complete her clinical training and secondly, that this was more difficult due to family commitments.

Sabrina also commented that she was pursuing an educational role because she anticipated wanting to have children in the future and that working in surgery fulltime was not particularly family friendly as she explained in the following exchange.

'...doing this Master's degree gives me an opportunity to balance my career later.'

JH - *'Can you say a little bit about what you mean by that?'*

'Yeah. By working as a surgeon but also have a job in education which is less.... Well at least less physically exhausting and maybe better, more compatible with a family life, so that might be an incentive, I'm not sure. At least for me it is.'

So, whilst this was not the only motivation for Sabrina to pursue a career in education (she went on to describe education as being *'very interesting and satisfying'*) it was an attractive aspect of this type of role. Having children, or wanting to have children, clearly impacted on the career choices that some participants made, with educational roles appearing more compatible with family responsibilities. This feature of educational roles was not referred to by any of the male participants.

Summary

It is clear from the interviews that there were a range of opinions and experiences when it came to differences in gender and medical education. Many of the gender differences reported by approximately a third of participants were reflected in the wider literature. For example females doing more teaching in general, being more caring and nurturing in their

approach and being more likely to take on the organisational and administrative tasks related to teaching. Where there were no gender differences reported (approximately two thirds of participants), most participants went on to describe differences between other groups that they had observed rather than between males and females. For example, differences in approaches to teaching by medics from different specialties, or differences being attributed to age, seniority and prior educational experiences. Some participants reported gender differences in specialties (often presented as a reason why they were unable to comment on gender differences because of or most of their colleagues were male or female) but this was often not commented on by the participant e.g. why they thought there were gender differences within specific specialties.

I may speculate as to how these observed differences might impact on how participants engage with the communities of medicine and education and how they may boundary cross between the two. For example, males and females may feel that they need to engage in gender appropriate behaviours e.g. males may feel the need to adopt the role of expert whilst this appears less comfortable for females. As John suggested, females may find it easier to engage with an interpretivist world view or student-centred methods which do not place teachers' subject expertise at the fore. For some participants the gendered nature of some specialties that they worked in also impacted on the type of educational activities and approaches that were acceptable.

4.7 Conclusion

This results chapter has considered the main findings from the participants' interviews as well as a small review of website of medical Royal Colleges and three medical journals. The findings from this study revealed the following key themes:

- Support for the view that medicine is made up of multiple communities and some differing views of education by different medical specialties.
- Participants engaged in a range of types of teaching to different groups of learners (students, colleagues, patients) in both clinical and non-clinical settings and thus education may also be viewed as multiple communities due to a lack of shared practice amongst this group of medical educators.
- Most of the participants experienced challenges in studying education at Master's level and in engaging with new ways of thinking about and conducting research.

- For many participants, completing their MEd provided both institutional and personal validation, as well as having a positive impact on their own practice. However, this was not universal in that the programme did not always meet their needs or was not viewed positively by colleagues.
- Some participants experienced frustration by the lack of desired trajectory within an educational community of practice, or the requirement to still have expertise in clinical skills to successfully navigate to the centre of this community.
- As suggested in previous literature, some participants experienced tensions resulting from the view of education being a lower status activity. However, for some participants this view was changing and education appeared to garner a different level of status in different contexts.
- Some participants appeared to manage these tensions, particularly where education was viewed as low status, by having a high level of identity capital.
- Gender differences in the way in which males and females engaged with medical education was recognised by approximately one third of participants and in some cases these differences were linked to issues of status. The remainder of participants recognised differences but attributed these to differences in medical specialities, level of seniority, or educational background.

Having considered the key themes from the data analysis the following chapter presents some discussion of these themes in further detail and considers these in light of both practical and theoretical implications.

Discussion

5.1 Introduction

This chapter will discuss the themes that emerged from the findings and relate these to the wider context of medicine as a changing profession as well as the existing literature on professional identity formation. The chapter begins by summarising the key findings and linking these with existing literature. Comparisons between participants' experiences of engaging with differing medicine and education communities of practice will be drawn and consideration given to the diversity of their professional practice. The dynamic nature of current medical practice is then considered as the backdrop against which the professional identity development of medical educators is taking place. Finally, the factors that may facilitate participants working across these two communities are discussed in more depth.

Links to previous literature

As summarised in the results chapter, the key themes from this study included medicine and education being made up of a variety of communities of practice, the work of identity development and the challenges that these medical educators experienced in engaging with education, the ways in which tensions were managed and the potential impact of gender on the role and practice of medical educators.

The findings from both the review of websites and journals, as well as participant interviews supported the view in some of the existing literature that medicine was made up of a number of communities of practice (Pugsley, 2012, Cantillon, 2016). Despite all the participants completing, or having nearly completed their MEd, there was variety in the range and amount of educational roles and activities that were engaged with. This finding indicates that education may also be considered to be made up of a variety of communities. There was also support for the claim for increased professionalisation of medical educators (Hu et al, 2015, Stoddard and Brownfield, 2016) with participants citing various reasons for pursuing Master's level study in education. The personal benefits of completing this qualification cited by participants supported previous findings in the literature, for example, an increased focus on utilising learner centred approaches (Burchard and Stoncel, 2011; Gibbs and Coffey, 2004; Hanbury, 2008). Although many participants cited positive aspects of completing their MEd, supporting the work of Sethi et al (2016), this was not the case for all participants. Some found that the course did not fulfil their expectations, often because it did not meet their learning needs. There were also

reported challenges of engaging with educational ideas and research methodologies, concurring with the experiences of Kneebone (2002) and Woolf (2006).

In relation to the theoretical framework of communities of practice, the findings from this thesis broadly support many of the key concepts proposed by Wenger and others. For many participants working across communities was challenging, supporting Wenger's (1998) view about the difficulty of brokering. However, Wenger also highlights the positive aspects of brokering and for some participants this resonated with their experience in that they were able to take on new roles, were viewed as experts by colleagues and gained personal satisfaction from this experience. However, for some participants their educational and clinical roles remained quite separate (e.g. Helena and Rohan) and therefore these benefits were not exploited.

The lack of an obvious medical education community to join or inbound trajectory experienced by some participants supports the findings of Stone et al (2002). However, in contrast some participants saw this as an advantage in that they were able to create their own educational role to suit them (e.g. Joan and Helena). Fenton-O'Creevy et al's (2015) concepts of '*sojourners*' was supported by the experience of some of the participants in terms of how they engaged with an educational community of practice. For example, those participants who had taken time out of medical training to focus on an educational role before returning to clinical practice. Clare, for example, had a high level of participation in medical education during her time as a teaching fellow, but on her return to clinical practice had limited engagement with education, thus was only '*passing through*' this education community. Few participants had a '*tourist*' experience, mainly because completion of a Master's degree in education necessitated a comparatively high level of participation. Those who had a more permanent position within an education community and high levels of participation were experiencing a more apprentice like role (Wenger, 1998), for example Helena and Hema.

Previous literature suggested that education had a lower status than research or clinical practice (Archer et al, 2015; Bartle and Thistlewaite, 2014; Hays, 2006; Klingensmith et al, 2006) and this was supported by some of the participants' experiences. However, there were also findings from this thesis which complicate this view, indicating that in some contexts, specific educational activities had increasing or even high status e.g. consultant teaching on a ward round or guest lecturing.

Many of participants' discussions about the impact of gender on medical education practice demonstrated a lack of conscious awareness about this aspect of their identity and role concurring with previous literature on the gender neutrality of the medical profession (Verdonk et al, 2007, Tsouroufli, 2016). The choice of engaging with education reported by some female participants supports the view of Riska (2009), in that working hours and flexibility appeared to play a part in this choice. Some participants made links between gender and the status of education, supporting Coate and Kandiko-Howson's (2016) findings on gender and prestige within academia. However, two thirds of participants reported experiencing no gender differences in education activities and practice, but rather attributed any differences to medical specialty, previous educational experience or personality differences.

In summary, the findings of this thesis support some of the previous literature on medical educators' identity development, their role as brokers and some of the tensions they experience in developing their identity. However, the findings also shed new light on the increasing status of education within medicine and higher education, as well as the perception of gender and its potential impact on participants' identity.

Having briefly discussed how these findings relate to the existing literature, I will now turn attention to discussing two key aspects that contribute to the complexity of developing a medical educator identity. Firstly, the diversity of practice will be considered. This has already been mentioned in relation to both medicine and education being made up of constellations of communities, rather than single communities, but will now be discussed in further detail. Secondly, the changing nature of the medical profession as the back drop against which this identity development is taking place will be discussed. These factors will be drawn together to present a model of identity development and to consider the factors that may impede or facilitate how medical educators may traverse a landscape of practice (Wenger-Trayner et al, 2015).

5.2 Diversity of Practice

The interviews revealed the diversity of the communities of practice of medicine and education that participants were working in. Within these two communities there were a variety of activities that participants were involved in and different levels of involvement in both medicine and education. For example, the practice of participants who were primarily based within a medical school context was more similar to other university lecturers. For

other participants, their practice was located within the clinical context for example teaching junior doctors or colleagues. The medical specialities from which participants worked within also varied with some participants engaging in varying amounts of clinical work and research in comparison to their educational work. There also appeared to be differences in how various specialities viewed education as an activity as reported in both the discourses about education on websites and in medical journals, as well as from participants' interviews.

These variances in these two sets of communities of practice resulted in many participants reporting tensions in negotiating and managing their professional identity as medical educators. One particular challenge was navigating a career path that enabled them to engage with education as much as they wanted (for example, Justin) and that made use of their educational expertise (for example, Hema). For others (for example, Clare), the difficulty was in ensuring that their clinical training was not compromised, or perceived to be compromised, by others. Seniority appeared to mitigate some of these tensions for example for Neil and Niamh, whilst more junior colleagues felt that they needed to complete their training in order to have perceived credibility by others (for example, John). Examples of this diversity are considered in more depth below, contrasting the experiences of Justin, Helena and Ben as illustrative examples.

Justin – Suggested that his speciality of psychiatry had similar underlying principles to education, mainly around a focus on the development of people. He also suggested that this was in some way linked to the fact that his sub specialty of child psychiatry was female dominated. Therefore, it might be expected that education would be valued and that Justin would experience fewer tensions around his professional identity. However, he indicated that this was not the case, that not all his colleagues valued education and that it was often difficult to find time for educational activities within the context of increased clinical pressures. He was motivated to increase the amount of educational activities that he was involved in but he did not feel that this was possible at the time.

Helena – Worked predominantly within a medical school which provided her with status and she argued that this was viewed as more prestigious than her clinical work as a general practitioner. Furthermore, she revealed that her clinical colleagues were largely unaware of her medical school work and that there was little cross over between the two. Therefore,

although Helena received value from her role within the medical school, this was not viewed with the same prestige by colleagues in her GP practice.

Ben – Although Ben described a significant range of teaching educational activities both within the clinical setting of surgery (e.g. teaching colleagues and junior doctors) as well as within the medical school such as supervising PhD students, he did not describe himself as an educator. Ben appeared to be mindful of the lower status attached to education, by others in the medical profession and within academia, highlighting the differing job titles and careers paths available to those who wished to focus on education.

These three examples demonstrate the diversity of participants' practice. Whilst all were qualified medical doctors with a Master's qualification in education, the educational activities that they undertook varied in range, type and context. The relative status of education varied with Helena experiencing high status and prestige from her educational role, whilst Ben reported on his experience of education as a lower status activity. There also appeared to be differences in how congruent their doctor and educator identities were with Helena and Ben appearing to have more separate identities, and Justin's being more aligned. This may be partly due to the similarities that he reported between education and psychiatry. These examples illustrate and highlight the range of experiences and diversity of practice of just three of the participants, but this diversity was present across the range of participants' interviews.

5.3 The Dynamic Nature of Medical Practice

The diversity of this professional identity development experienced by participants is further complicated by the dynamic context of the medical profession in which this process is taking place. As Wenger (1998) argues '*practice entails the negotiation of ways of being a person in that context*' (p.149). However, the context of medicine is changing and therefore this diversity of professional identity development is taking place within a fluid and dynamic environment.

Examples of this dynamic nature include significant changes within medicine and medical education at both a policy level and a practice level. These changes are mainly focused on two drivers. Firstly, there have been significant changes in the health needs of the population. It is well documented that there is an ageing population who are likely to suffer

from several complex health conditions such as obesity, diabetes and hypertension (RCP, 2010). At the same time, stays in hospital are becoming shorter but more acute and there is a greater emphasis being placed on delivering healthcare within community settings (Pugsley, 2012, Barker et al, 2017). Therefore, medical education needs to consider how more doctors can be trained to be generalists rather than specialists, and to be better able to manage complex patient needs. Furthermore, there is a move towards more patient centred care, and increasingly to person centred care (Miles and Mezzich, 2011), including a rise in the expert patient role (Puglsey, 2012). In this climate, doctors need to work as translators, guides and interpreters rather than adopting a doctor-centric, paternalistic role. However, undergraduate medical education has perhaps yet to catch up with this need. There is often incongruence between the undergraduate curriculum which is still siloed and specialised and the need for medicine to be more holistic, humane, and generalist.

A second driver is the increasing concerns about the workforce of doctors, particularly in relation to the number of doctors leaving the profession and the proportion of junior doctors who are not continuing their clinical training (Rimmer, 2017a). Therefore, there are calls to review postgraduate training and consider what could be done to make the training environment more flexible and supportive (Rimmer 2017b). It is becoming more acceptable for clinical training to take longer, longer partly because of an increase in the training requirements such as undertaking a PhD. As the GMC (2017) has concluded,

'The current generation of doctors want more flexibility in the way they are trained. They are deeply committed to proving high quality care to patients but they want training pathways that can adapt to their needs, enhancing and widening career choices.'

(p.6)

There is also demand from doctors for part time working and flexible training posts (RCP, 2010) and calls for postgraduate medical training to be tailored for 'Generation Y'³ (Twigg, 2017). Furthermore, there are trends to broaden the role and remit of doctors including an increased emphasis on entrepreneurship, attributed to medical students and trainees being digital natives and adopting a 'fix it mentality' (Limb, 2017). There is also increased importance placed on doctors engaging in medical leadership (RCP, 2010). Additional concerns about the workforce of doctors including those related to physician burnout (Chopra et al, 2004; Gundersen, 2001; McCray et al, 2008) and the wellbeing and resilience

³ Generation Y is the term used to refer to those individuals born between the early 1980s and later 1990s.

of medical students (Brazeau et al, 2010; Dunn et al, 2014; Kjeldstadli et al, 2006; Thomas et al, 2007;) as well as calls to address workplace bullying (Quine, 2002).

These changes within the medical profession and medical education have implications for the identity and role of medical educators. The demand for flexible work and training, and opportunities to pursue interests such as medical leadership and entrepreneurship should lead to a more expansive educational experience for medical students and trainees.

Medical educators must look to move away from a focus on the transmission of knowledge and the privilege of specialism and rather focus on supporting learners to develop a board based expertise as well as the attitudes and approaches that patients are now requiring from doctors. Potentially a more humanistic approach to medical education needs to be adopted in order to address issues of student and trainee wellbeing and resilience.

The diagram below attempts to show the key influences on the professional identity of medical educators, including acknowledgement the wider context in which this identity development is taking place.

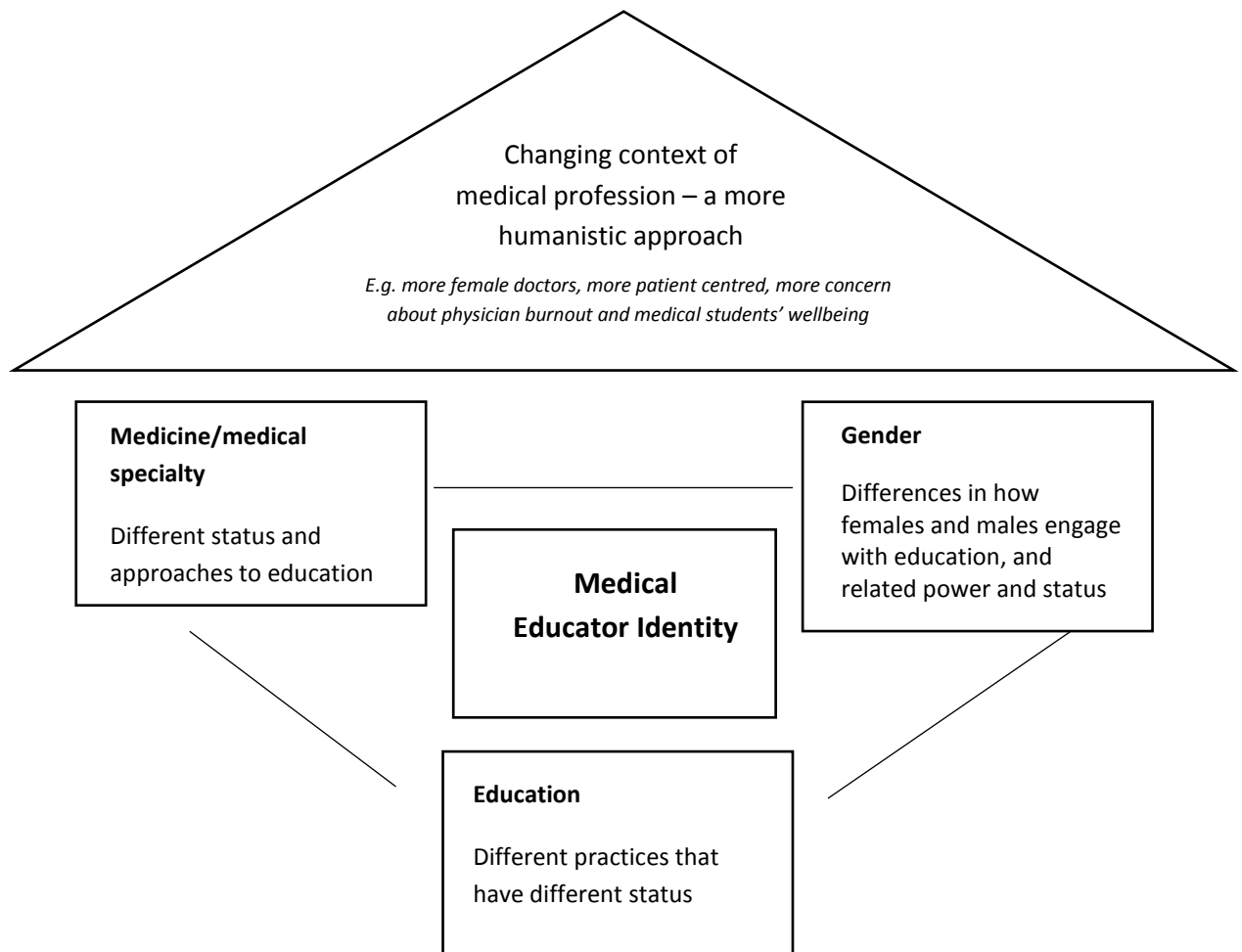


Figure 2.

As can be seen, different medical specialities view education through different lenses, valuing different educational practices. The participants in this study all described different educational roles and activities that they were involved in and thus, education in this context does not necessarily have a shared frame of reference or set of practices. It also appeared that different educational activities had different levels of status. Whilst education overall was seen by many participants as being of lower status than their clinical practice and/or clinical research (Helena being a notable exception), within education itself different activities had varying status and prestige. For example, lecturing and in some cases, clinical teaching by consultants were both seen as high-status activities. In contrast, course organisation and other teaching administration were viewed as having lower status. Both the differing activities, as well as the associated prestige of these activities, were seen by some as related to gender. This all takes places under the dynamic context of the medical profession as a whole, with an increased focus on more humanistic and holistic approaches to patient care.

There was suggestion by some participants that this more patient centred, nurturing approach was becoming more important and that this may be more closely aligned with the aims and ideas of education as a discipline. This potentially raises the profile of education and increases the prestige of those medics who want to engage more with an educational community and can act in a brokering role.

As a result of this changing context, we perhaps need to problematise our assumptions about what medical education is in order to take account of these changing demands from both doctors about what they want from their profession and from patients about the type of healthcare that they want and need. As Lord Woolf stated,

'in a profession like medicine which is moving forward with tremendous rapidity...you really are going to have to be constantly educating and re-educating the profession so that...they do not fall behind the current standards.'

(RCP, 2010, p.8).

Therefore, the education of doctors needs to be more fluid and adaptable, broader but more personalised in order to meet these changing demands. As a result of the role of the medical educator will need to change and develop. Much like the role of the doctor is moving away from a paternalistic, expert position, so too may medical educators need to adopt a role that is more facilitative and guiding. Whereas previously, medical educators may have focused on the transmission of a body of knowledge, the exponential increase in medical knowledge (Densen, 2011) means that this is no longer possible to keep up with. Furthermore, the objective body of knowledge that once characterised medicine (Winch, 2004) is no longer privileged but can be accessed by many through the democratisation of knowledge. However, this may prove challenging to some medical educators who may be unconformable with this culture change. Some may feel that their position as expert is being threatened or that standards are being lowered.

The key influences on medical educators' identity development, as summarised in figure 2 may impact on individuals differently. A different combination of medical speciality, educational activity combined with the influences of status and gender will lead to differing experiences and expressions of professional identity development for different groups of medical educators. This also indicates that there are different ways in which these individuals navigate the landscape of medical education practice and the factors that make this more or less challenging.

5.4 Bridges over Troubled Water

The data suggested that whilst studying for a MEd was ultimately positive for many of the participants, engaging with education as a new field of study was challenging for most. These challenges, as outlined in the results chapter, included engaging with new ways of thinking, carrying out research in a new methodological paradigm, and using new terminology. Furthermore, participants experienced tensions in engaging with education in their professional role. These tensions included the lower status of education that some participants experienced, not being able to share their new knowledge and understanding with colleagues, and finding the time for education alongside busy clinical commitments. Inspired by Wenger- Trayner et al's (2015) metaphor of landscapes of practice these findings therefore suggest that crossing between medicine and education involved crossing some '*troubled water*'. However, it appeared from the participants' interviews that there were some '*bridges*' that facilitated these crossings and therefore helped participants to develop their identity as an educator. These '*bridges*' included the following:

- completing a MEd, which for several participants provided them with validation as a medical educator;
- working in a clinical or academic environment where education was perceived positively and their expertise recognised and utilised;
- engaging in the type of educational practice that had high or increasing esteem;
- gaining personal satisfaction from teaching
- being able to navigate a desired trajectory within an educational community of practice.

These bridges appeared to be shorter, and therefore easier to cross, where there were greater similarities between the participants' medical community and their educational one. Participants might also need to assess the risk of falling from these bridges. For example, if there was personal gain from engaging with education because of internal motivation or because it suited their desired lifestyle, then these factors lowered the risk of falling. The amount of identity capital that a participant held perhaps provided a safety net. For example, those with higher levels of identity capital because of the status of their clinical practice and/or research appeared to experience fewer tensions in developing their educator identity because the risk of engaging with the lower status activity of education was offset by their identity capital. These bridges were used to traverse the landscape of practice that participants engaged with (Wenger-Trayner et al, 2015).

5.5 Conclusion

This discussion chapter has considered the factors that impact on the professional identity development of medical educators who are graduates of MEd courses and how these findings provide support for or challenge existing literature. The identity development of these medical educators was made particularly complex, firstly by the diversity of practice in which they engaged and secondly by the dynamic nature of current medical practice and the medical profession. The implications of these drivers suggest a changing role and identity for medical educators which may provide opportunities for some and challenges for others. The metaphor of '*bridges over troubled water*' was proposed as a way of conceptualising how these educators may traverse the medical education landscape of practice (Wenger-Trayner et al, 2015).

CONCLUSION

6.1 Introduction

The previous discussion chapter examined the key findings of this study in light of the existing literature as well as considered how the current state of medical practice and the role of the doctor may impact on the identity development of medical educators. In order to traverse the '*landscape of practice*' suggested by Wenger-Trayner et al (2015), the metaphor of '*bridges over troubled water*' was proposed. This chapter therefore aims to offer some concluding comments about these findings, and point towards future recommendations and further research. Firstly, the aims and research questions will be revisited and consideration given to how these have been answered by this study. Secondly, the contribution of this study to both theory and practice will be outlined. Thirdly, limitations of the study will be discussed and recommendations for future research are proposed. Finally, I consider my own role and development as a researcher through the process of conducting this study.

6.2 Revisiting Aims and Research Questions

Building on from my Institution Focused Study, the aim of this thesis was to explore the ways in which medics (surgeons, psychiatrists, physicians, general practitioners etc.) who were graduates of, or were currently completing, a Master's in Education course, developed and negotiated their medical educator professional identity. Each of the research questions will be considered in light of these findings.

1. How do medics develop their medical education identity and what may be the similarities and differences between different groups of medics (surgeons, psychiatrists, physicians, general practitioners etc.) in this respect?

Given the relatively small number of participants from each of these specialities it would be unwise to draw firm conclusions in relation to this question. However, there were some suggestions from both the interviews, as well as the review of journals and websites, that education was viewed differently by different specialities. For example, there appeared to be greater overlap with the underlying aims and values of education and psychiatry as evidenced by both a review of the Royal College of Psychiatrists' website as well as Justin's interview, whilst surgery, had the perception at least, of employing more teacher centric, didactic methods.

However, as previously discussed, the experience of the participants was not as straightforward as one specialty valuing education highly and another seeing it has having lower status. Even when education was valued highly, there was often tensions with clinical service delivery, for example Justin's experience working as a psychiatrist.

2. How do different participants (reflecting a range of specialties) broker their identity between the different communities of practice of medicine and education?

Several participants, for example Ali and Louise, took on their broker role positively, were viewed as an expert, and invited to be involved in educational activities and projects. However, for others there was often a lack of support, as seen in Clare's interview, as well as a lack of career progression within medical education as discussed by Hema and Helena. Some participants foregrounded either their clinical or educational role above the other as a way of managing their identity. For example, Helena whose educational role appeared more central to her professional identity, whilst for Ben this appeared to be more of a peripheral part of his identity. For some, their educational and clinical identities were more intertwined, for example Niamh who spoke about the, albeit complex, situation of teaching students whilst seeing patients in clinic, or Louise who discussed teaching patients as part of her role as a doctor.

3. Based in these experiences and comparisons, what factors appear to be influential on the shaping of professional identity of medical educators.

Clearly completing a MEd, impacted on participants' identity. This may be considered an example of reification (Wenger, 1998), because not doing a MEd does not prevent medics from engaging in medical education, and therefore those who do are setting themselves apart in some way. Completing a MEd appeared to challenge most participants' professional identity in terms of learning new terminology, what they considered to be valid research and adopting a less '*black and white*' way of thinking, as discussed by Helena and Hema. Furthermore completion of a MEd impacted on how some participants thought of themselves as teachers and how they were considered by colleagues as having expertise in education. Along with their MEd studies, various other factors impacted on their identity development as medical educators. For example, working in an environment where education was valued, engaging in educational activities that were held in higher esteem, and being able to navigate their way to a more central position within an educational

community if this was desired. These factors could be considered to act as bridges between medicine and education communities of practice.

6.3 Contribution to Theory and Knowledge

Using the theory of communities of practices as a basis to explore the identity development of medical educators is not necessarily novel (e.g. Cantillon, 2016). However, this study has explored some of the complexity of medical and educational communities of practices and has highlighted the factors that enabled participants the cross between them. For example, as well as supporting the view that medicine is several communities of practice (Baszanger, 1985, Pugsley, 2012, Cantillon, 2016), this thesis also suggests education is not a single community of practice with participants engaging in a range of educational practices in a variety of contexts and to varying degrees. The review of websites and journals revealed some insights into the wider context in which medical educators were developing their identity, as well as the messages that they may receive about the role and value of education within the medical profession.

A criticism levelled at Wenger's original work on communities of practice was the failure to acknowledge the role of power and status in identity development (Contu and Wilmott, 2003). These are features prevalent in many workplaces but particularly so in medicine given the hierarchical nature of the profession. This study attempts to address this by considering the status of education compared with other aspects of medics' professional practice and how this impacts on their identity as educators. Previous research has suggested the education has been commonly viewed as having a lower status than research and clinical practice (Archer et al, 2015; Bartle and Thistlewaite, 2014; Hays, 2006, Klingensmith et al, 2006). However, this study found that although this was still the case for some participants, many were noticing an increase in the status of education, often linked to money and/or standards of patient care. A few participants were viewed as experts in education, and whilst it is difficult to draw a direct link between this and the increasing status of education, it seems reasonable to suggest that their expertise may be given greater prestige if this is a continuing trend.

A further contribution of this study is the focus on the role of gender in medical educators' identity development. As outlined in the literature review the focus on gender was chosen because of the changing nature of the male/female ratio within medicine (Bleakley, 2013; Carvajal, 2011; Riska, 2009) as well as previous literature highlighting the gendered nature of teaching within higher education (Becher and Trowler, 2001, Deem, 2003). Furthermore,

whilst there is existing literature on the impact of gender on the experiences of medical students (e.g. Burgo and Josephson, 2014; Higham and Steer, 2004), the influence of gender on medical educators' identity remains relatively under-researched. In contrast to the literature that does exist about gender and medical educators' identity (e.g. Masunaga and Hitchcock, 2011) this thesis employed the use of interviews to explore in more depth participants' views around gender and medical education. The findings revealed the perception of participants as to the possible relevance of gender within medical education and suggests some links between participants' gender and their perceptions of the status of educational activities, supporting the view of Coate and Kandiko-Howson (2016) amongst others. Furthermore, some participants were able to cite examples of gendered activities within medical education, for example males teaching in a more didactic manner or females presenting research in less authoritarian ways. Others, all female, cited family reasons for wanting to pursue medical education as a role that had more predictable working hours. However, for many participants this appeared to be an unexplored part of their identity and medical education more generally. Despite this, the impact of gender on medical educators' identity and role is likely to be a factor that needs further examination as part of efforts to reform medical education within the dynamic nature of medical practice.

6.4 Contributions to the Professional Practice of Medical Educators

As well as contributing to the theory around the professional identity development of medical educators, this thesis also has practical implications. It is becoming increasingly more common for clinicians to complete at least a PGCert in Education if not go on to complete a full Master's in Education, with anecdotal evidence suggesting that holding a PGCert qualification is a requirement for consultant posts. Whilst there is significant research on around faculty development for medics generally, there is more limited research that specifically focuses on the impact of those who study for postgraduate qualifications in education.

Therefore, considering the development of these of medical educators and how they work across differing communities of practice is becoming increasingly important. The challenge of crossing disciplinary paradigms is reasonably well documented in the literature (e.g. Kneebone, 2002; Woolf, 2006) but this study suggests that the challenges varied depending on the participants' local context, medical specialty, identity capital and so on. Therefore, programme leads for MEd courses, as well as those working in faculty development more

widely, need to be aware of these differences, and the distance that an individual student might need to travel to cross the paradigm gap. As Wenger-Trayner et al (2015) suggest these boundary crossings should be seen as a '*learning asset*' (p.18) and therefore should not be hidden. In order to support this boundary crossing, these challenges should be made explicit by Master's in Education course leads and tutors. Students should be provided opportunities to be reflexive about the contexts they are working in and more tailored personal tutoring to support the differential needs of students.

Where participants had a positive experience post MEd, this was often due to local context and set up. For example, they found themselves in an environment where education was valued or had a position in which they could develop the educational aspects of their role and identity. A lack of support or clear pathways post MEd was cited by a few participants as being problematic and resulted in them not implementing their new knowledge and skills as much as they would like. Therefore, the medical education community should consider what structures could be put in place in order to enable the implementation of knowledge and skills within the local context. However, given the range of activities that participants were engage with and the different trajectories that they took it is unlikely that one approach would be beneficial to all and would potentially stifle the variety of work and practice that was appealing to many participants.

6.5 Limitations of the Study

There were several limitations to this study which may impact on how strongly the conclusions can be presented.

The study was relatively small scale, primarily due to the constraints of completing an EdD thesis and thus I acted as a lone researcher with limited resources. This meant that I was the only researcher who conducted and analysed the interviews and whilst I put in places strategies to verify aspects of my data collection and analysis such as sending transcripts of the interview to participants and sharing these with my supervisor, there was no formal internal review of my analysis by a second independent researcher. However, I attempted to remain reflexive as a researcher (Green and Thorogood, 2014) and mindful of my own biases and assumptions through several measures. Firstly, I used strategies such as writing a research diary, thereby keeping a record of my thoughts and decisions which enabled me to analyse these. Secondly, I had regular meetings with my EdD peer group in which we discussed our research at every stage, thereby getting peer feedback on the approaches taken and decisions made. Thirdly, I also had the opportunity to present parts of this

research as both local and international conferences, and again this provided me with feedback from other academics outside of my local context. However, future research would benefit from a co-researcher particularly at the data collection and analysis stages.

A further limitation was that the study only recruited participants who were currently studying for, or had completed, a Master's in Education. The reasons for this have been explained in the rationale section, including what previous research has found, my own professional interest in this group of professionals, and practical reasons to ensure that comparisons could be made across the interviews. However, it could be argued, as Natasha did in her interview, that most medical education was undertaken by those without formal qualifications and limited professional development in, for example, lecturing or teaching in clinical settings. Exploring the experiences and professional identity development of these medical educators would certainly be an aspect for further research.

All the participants in this study had also undertaken their Master's in Education study within the UK and therefore there may be differences in MEd programmes from other countries. This limits the transferability of the results to an international context.

For practical reasons not all the interviews were conducted face to face and in a few cases, were significantly time bound, with participants only being able to provide a limited amount of time. For example, Ben's interview took place at 7am prior to the start of his ward round, whilst Sabrina was interviewed at 5.30pm after a long teaching day. Jason and Natasha also prefaced their interviews by indicating a time that they would need to be finished by and checking my expectations about how much time we had together. This perhaps impacted on how much depth could be gone into during the interviews and such examples highlighted and reinforced the tensions that I had of asking busy professionals to give up time to be interviewed

Furthermore, because of the nature of the type of research that I was conducting (time and resource limited) I completed 15 interviews and because I relied on volunteer and snowball sampling I was not able to recruit equal numbers of participants from different specialities. This therefore makes some of the comparison between specialities more difficult and tentative. Clearly this would be an area for further research.

6.6 Recommendations for Future Research and Directions

Given both the findings of this thesis and the limitations highlighted, there are several recommendations for further research. The findings suggested that there were some

differences in the experiences of participants from different specialities. Further research would be needed to explore these differences more robustly. As mentioned above, much medical education is undertaken by those who have not completed a MEd course and therefore it would be useful to explore their experiences. Are these similar or different to those who had undertaken postgraduate study? As discussed in the literature review section, there was rationale for focusing on gender and using this as a lens to explore differences between participants and the links with power and status within medical education. However, this does ignore the issues of intersectionality and how various aspects of an individual's identity may intersect and result in differing experiences (Tsouroufli et al, 2011). Therefore, future research could analyse the experiences of medical educators by ethnicity, age, seniority etc.

During the interviews I was reliant on participants' recollection of their experiences which may be influenced by memory or by certain biases such as what they were willing to share with me. Furthermore, undertaking this RBT has also made me more aware of how medical educators behave and speak, and how others react to them, as I often observed what might be referred to as 'micro aggressions' (Wing Sue, 2010). Therefore, adopting an ethnographic approach may be appropriate to better understand the socialisation process that medical educators experience (Pugsley, 2012).

6.7 Personal Reflections

Like all part time EdD students with a busy full-time job and family life, completion of this thesis has, on occasions, been challenging. Refining the scope of the research and negotiating the appropriate channels for ethical approval felt at times, like an uphill struggle, whilst in contrast the process of interviewing participants and analysing the data was more akin to freewheeling down the other side. The most enjoyable part of the research was interviewing participants all of whom had interesting and varied experiences to share. It was a great privilege for these busy professionals to give up time to speak with me and to share their thoughts and feelings which they may not have shared with others before. I was therefore very conscious that this work should do them justice. I have endeavoured to implement the learning points from earlier parts of the EdD not only in terms of previous reading and understanding, but also my approach to carrying out this research.

There is no doubt that the process of completing this RBT and the EdD in general has informed my own professional practice immeasurably. This has been not only in how I

support my own MEd students in light of these findings but also in how I teach research methodology and methods. I am much more familiar with different research methodologies and their underlying philosophical positions. I am more confident in my understanding of what qualifies as rigour in qualitative research and how to ensure that this and future pieces of research are as robust as possible. My understanding of, and familiarity with, the literature on professional identity development in general and specifically the medical education literature has been enhanced enormously. Several of my MEd students have undertaken research into identity development of various groups or communities of practice and I have been able to guide them in terms of relevant literature and methods.

This work has also informed other pieces of research I have undertaken, as well as given me opportunities to present at academic conferences and co-author a book chapter on the identity development of surgeon educators (Cuming and Horsburgh, in press).

References

- Academy of Medical Education (2014) *Professional Standards (3rd Ed)*. Cardiff. Academy of Medical Educators.
- Academy of Medical Royal Colleges (2017) *About Us* <http://www.aomrc.org.uk/about-us/> [accessed 6th December 2017].
- Akkerman, S.F., and Bakker, A. (2001) 'Boundary crossing and boundary objects', *Review of Educational Research*, 81, 132-169.
- Albert, M., Hodges, B., and Regehr, G. (2007) 'Research in medical education: Balancing service and science', *Advances in Health Sciences Education*, 12, 103-115.
- Anderson, C. (2010) 'Presenting and evaluating qualitative research'. *American Journal of Pharmaceutical Education*, 74(8), 1-7.
- Archer, J., McManus, C., Woolf, K., Monrouxe, L., Illing, J., Bullock, A., and Roberts, T. (2015) 'Without proper research funding, how can medical education be evidence based?' *British Medical Journal*, 350:h3445.
- Armstrong, E.G., Doyle, J and Bennett, N. (2003) 'Transformative professional development of physician as educators: Assessment of a model', *Academic Medicine*, 78(7), 702-708.
- Association for the Study of Medical Education (2007) *A History of ASME: 1957-2007*. Edinburgh: ASME.
- Babbie, E. (2017) *The Basics of Social Research*. 7th edition. Boston, MA: Cengage Learning
- Baddeley, R. (2017) 'A junior doctor by any other name', *British Medical Journal*, 359, j4797.
- Baker, L., Egan-Lee, E., Martimianakis, M.A. and Reeves, S (2011) 'Relationships of power: Implications for interpersonal education', *Journal of Interprofessional Care*, 25(2) 98-104.
- Bannard-Smith, J. Bishop, S., Gawne, S., and Halder, N. (2012) 'Twelve tips for junior doctors interested in a career in medical education', *Medical Teacher*, 34(12), 1012-1016.
- Barbour, R. (2013) *Introducing Qualitative Research: A Student's Guide*. London: Sage Publications.
- Barker, I., Steventon, A. and Deery, S.R. (2017) 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected person level data', *British Medical Journal*, 356, j84.
- Bartle, E. and Thistlethwaite, J. (2014) 'Becoming a medical educator: motivation, socialisation and navigation', *BMC Medical Education*, 14, 110.
- Barton, D and Tusting, K. (2005) *Beyond Communities of Practice. Language, Power and Social Context*. Cambridge: Cambridge University Press.

Barts and the London School of Medicine and Dentistry (2016) 'Intercalated BSc in Medical Education'

<http://www.smd.qmul.ac.uk/undergraduate/courses/intercalated/me/index.html>

[accessed 30th Dec 2016].

Baszanger, I. (1985) 'Professional socialization and social control: From medical students to general practitioners', *Social Science and Medicine* 20(2), 133-145.

Baxter, N., Cohen, R. and McLeod, R. (1996) 'The impact of gender on the choice of surgery as a career', *American Journal of Surgery*, 172, 373-376.

Beauchamp, C. and Thomas, L. (2009) 'Understanding teacher identity: an overview of issues in the literature and implications for teacher education', *Cambridge Journal of Education*, 39 (2), 175-189.

Becher, T. and Trowler, P.R. (2001) *Academic Tribes and Territories (2nd Edition)*, Buckingham: SRHE and Open University Press.

Beijaard, D., Verloop, N and Vermunt, J.D. (2000) 'Teachers' perceptions of professional identity: an exploratory study from a personal knowledge perspective', *Teaching and Teacher Education*, 16, 749-764.

Beijaard, D., Meijer, P.C. and Verloop, N. (2004) 'Reconsidering research on teachers' professional identity', *Teaching and Teacher Education*, 20, 107-128.

Blackmore, P. and Kandiko, C.B. (2011) 'Motivation in academic life: a prestige economy', *Research in Post-Compulsory Education*, 16(4), 399-411,

Bleakley, A., Bligh, J. and Browne, J. (2011) *Medical Education for the Future. Identity, Power and Location*. Dordrecht: Springer.

Bleakley, A. (2013) 'Gender matters in medical education', *Medical Education*, 47, 59-70.

Bleakley, A. (2014) *Patient Centred Medicine in Transition*. London: Springer.

Bligh, J., and Parsell, G. (1999) 'Research in medical education. Finding its place', *Medical Education*, 33(3), 162-163.

Boerboom, T.B.B., Dolmons, D.H.J.M., Muijtens, A.M.M., Jaarsma, A.D.C., Van Beukelen, P. and Scherpbier, A.J.J.A. (2009) 'Does a faculty development programme improve teachers' perceived competence in different teacher roles?' *Medical Teacher*, 31, 1030-1031.

Bourdieu, P. (1997) 'The forms of capital'. In A. Halsey, H. Lauder, P. Brown, A.S. Wells (eds.) *Education: Culture, Economy, Society*. Oxford: Oxford University Press.

Bourdieu, P. and Wacquant, L. (1992) *An Invitation to Reflexive Sociology*. Cambridge: Polity Press.

- Brazeau, C.M.L.R., Schoeder, R., Rovi, S., and Boyd, L. (2010) 'Relationships between medical student burnout, empathy and professional climate', *Academic Medicine*, 85(10), s33-s36.
- Bress, P. (2000) 'Gender differences in teaching styles'. *English Teaching Forum*, 38, 4.
- British Medical Association (2017) *Medical Training Pathway*
<https://www.bma.org.uk/advice/career/studying-medicine/insiders-guide-to-medical-specialties/medical-training-pathway> [accessed 28th December 2017].
- Brosnan, C. (2010) 'Making sense of differences between medical schools through Bourdieu's concept of 'field''. *Medical Education*, 44, 645-652.
- Brown, J.S., and Duiguid, P. (1991) 'Organizational learning and communities of practice: towards a unified view of working, learning and innovation', *Organizational Science*, 2, 40-57.
- Bryman, A. (1988) *Quantity and Quality in Social Research*. London: Routledge.
- Budden, C.R., Svechnikova, K. and White, J. (2017) 'Why do surgeons teach? A qualitative analysis of motivation in excellent surgical educators', *Medical Teacher*, 39 (2), 188-194.
- Burcher, J. and Stoncel, D. (2011) 'The impact of a postgraduate certificate in teaching in higher education on university lecturers appointed for their professional expertise at a teaching-led university: 'It made be braver'', *International Journal for Academic Development*, 17(2), 149-162.
- Burgess, R.G. (1981) 'Keeping a research diary', *Cambridge Journal of Education*, 11(1), 75-83.
- Burgo, C.M. and Josephson, A. (2014) 'Gender differences in the learning and teaching of surgery: a literature review', *International Journal of Medical Education*, 5, 110-124.
- Burnard, P., Gill, P., Stewart, K, treasure, E. and Chadwick B. (2008) 'Analysing and presenting qualitative data', *British Dental Journal*, 2014(8), 429-432.
- Cantillon, P., D'Eath M., De grave, W., Dornan, T. (2016) 'How do clinicians become teachers? A communities of practice perspective', *Advances in Health Science Education*. 21, 991-1008.
- Carvajal, D. (2011, March 8). The changing face of Western medicine. *International Herald Tribune*, p. 1.
- Cassell, J. (1997) 'Doing gender, doing surgery: Women surgeons in a man's profession', *Human Organization*, 56(1), 47-52.
- Charmaz, K. (2014) *Constructing Grounded Theory*. London: Sage Publications.
- Chopra, S.S., Sotile, W.M., Sotile, M.O. (2004) 'Physician burnout'. *Journal of the American Medical Association*, 291(5), 633.

- Coate, K. and Kandiko Howson, C. (2016) 'Indicators of esteem: gender and prestige in academic work', *British Journal of Sociology of Education*, 37(4), 567-585.
- Cohen, J.L. (2010) 'Getting recognised: Teachers negotiating professional identities as leaners through talk', *Teaching and Teacher Education*, 26, 473-481.
- Cohen, R., Murnaghan, L., Collins, J and Pratt, D. (2005) 'An update on Master's degrees in medical education', *Medical Teacher*, 27(8), 686-692.
- Cohen, L., Manion, L. and Morrison, K. (2011) *Research Methods in Education*. London: Routledge.
- Contu, A and Wilmott, H (2003) 'Re-embedding Situatedness: The importance of power relations in learning theory', *Organization Science*, 14(3) 283-296.
- Cope, A., Bezemer, J., Mavroveli, S and Kneebone, R. (2016) 'What attitudes and values are incorporated into self as part of professional identity construction when becoming a surgeon?' [published online ahead of print Nov 8, 2016] *Academic Medicine*, doi 10.1097/ACM.0000000000001454.
- Corbin, J. and Strauss, A. (2015) *Basics of Qualitative Research*. Los Angeles: Sage.
- Cote, J.E. and Levine, C.G. (2002) *Identity Formation, Agency and Culture. A Social Psychological Synthesis*. New Jersey: Lawrence Erlbaum Associates.
- Cristancho, S and Fenwick, T (2015) 'Mapping a surgeon's becoming with Deleuze'. *Medical Humanities*, 41,128-135.
- Cristancho, S. and Varpio, L. (2016) 'Twelve tips for early career medical educators', *Medical Teacher*, 38, 358-363.
- Cruess, R.L., Cruess, S.R. and Steinert, Y. (2017). 'Medicine as a community of practice: Implications for medical education'. *Academic Medicine*, doi 10.1097/ACM.0000000000001826
- Cuming, T. and Horsburgh, J. (in press) 'Constructing surgical identities – becoming a surgical educator'. In D. Nestel, K. Dalrymple, J. Paige and R. Aggarwal (Eds) *Advancing Surgical Education: Theory, Evidence and Practice*. Dordrecht: Springer.
- Dall'Alba, G (2009a) 'Learning professional ways of being: Ambiguities of becoming', *Educational Philosophy and Theory*, 41(1), 34-45.
- Dall'Alba, G. (2009b) *Learning to be Professionals*. Dordrecht: Springer.
- Deem, R. (2003) 'Gender, organisational cultures and the practices of manager-academics in UK universities', *Gender, Work and Organisation*, 10(2) 239-259.
- Department for Business, Innovation and Skills (2016) *Success as a Knowledge Economy: Teaching Excellence, Social Mobility and Student Choice*. London: Stationery Office.

- De Cossart, L. and Fish, D. (2005) *Cultivating a Thinking Surgeon*. Shrewsbury: TFM Publishing.
- Densen, P. (2011) 'Challenges and opportunities facing medical education', *Transactions of the American Clinical and Climatological Association*, 122, 48-58.
- Department of Health (2004) *Modernising Medical Careers- The Next Steps*. London: DoH.
- De St Croix, T. (2015) *Passion and resistance: Grassroots youth work in a changing policy context*. Unpublished PhD thesis. King's College, London.
- DiCicco-Bloom, B., and Crabtree, B. (2006) 'The qualitative research interview', *Medical Education*, 40, 314-321.
- Dimitroff, A. and Davis, W.K. (1996) 'Content analysis of research in undergraduate medical education', *Academic Medicine*, 71(1), 60-67.
- Dominelli, L. (1998) 'Women, social work and academia' in D. Malina and S. Maslin-Prothero (Eds) *Surviving the Academy: Feminist Perspectives*. London: Falmer.
- Drudy, S. (2008) 'Gender balance/gender bias: the teaching profession and the impact of feminisation', *Gender and Education*, 20(4), 309-323.
- Dunn, L.B., Iglewicz, A., Moutier, C. (2014) 'A conceptual model of medical student wellbeing: promoting resilience and preventing burnout', *Academic Psychiatry*, 32, 44-53.
- Edwards, R. and Holland, J. (2013) *What is Qualitative Interviewing?* London: Bloomsbury Academic.
- El-Harasis, M.A., Shalhoub, J., Marathappu, M and Warren, O. (2014) 'The Shape of Training Review: Broadening the non-clinical curriculum is essential for good patient care', *Postgraduate Medical Education Journal*, 90, 673-674.
- Erikson, E. H. (1950). *Childhood and society*. New York: Norton.
- Fenton-O'Creevy, M., Brigham, L., Jones, S., and Smith, A. (2015) 'Students at the academic-workplace boundary' in Wenger-Trayner, E., Fenton-O'Creevy, M., Hutchison, S., Kubiak, C., and Wenger-Trayner, B. (2015) *Learning in Landscapes of Practice*. London: Routledge.
- Forsey, M. (2012) 'Interviewing individuals'. In S. Delamont (Ed) *Handbook of Qualitative Research in Education*. Cheltenham: Edward Elgar Publishing.
- Freedman, J. (2001) *Feminism*. Buckingham: Open University.
- Fry, H. and Kneebone, R. (2011) *Surgical Education. Theorising an Emerging Domain*. Dordrecht: Springer.
- Furmedge, D., Verma, A., Iwata, K., Belcher, R., Ntatskai, E., Smith, L.J., Myers, G., Bennet, S. and Sturrock, A. (2013) 'The rise of clinical teaching fellowships'. *BMJ Careers*.

Gee, J.P. (2001) 'Identity as an analytical lens for research in education'. *Review of Research in Education*, 25, 99-125.

Gee, J.P (2005) 'Semiotic social spaces and affinity spaces. From the age of mythology to today's schools'. In D, Barton and K, Tusting (2005) *Beyond Communities of Practice. Language, Power and Social Context*. Cambridge: Cambridge University Press.

General Medical Council (1993) *Tomorrow's Doctors* London: GMC.

General Medical Council (2009) *Tomorrow's Doctors Medical Education*. London: GMC.

General Medical Council (2015a) *Promoting Excellence: Standards for Medical Education and Training*. London: GMC.

General Medical Council (2015b) *Outcomes for Graduates*. London: GMC.

General Medical Council (2016) *Recognition and Approval of Trainers* <http://www.gmc-uk.org/education/10264.asp> [accessed 19th Dec 2016].

General Medical Council (2017) *Adapting for the Future: A Plan for Improving the Flexibility of UK Postgraduate Medical Training*. Manchester: GMC

Gibbs, G. and Coffey, M. (2004) 'The impact of training of university teachers on their teaching skills, their approach to teaching and the approach to learning of their students', *Active Learning in Higher Education*, 5(1), 87-100.

Gill, D. and Griffin, A.E. (2009) 'Reframing medical education research: let's make the publishable meaningful and meaningful publishable', *Medical Education*, 43, 933-935.

Gill, D., Griffin, A., Woolf, K., and Cave, J. (2009). 'Twelve tips for studying medical education at doctoral level', *Medical Teacher*, 31(7), 601-604.

Goffman, E. (1959) *The Presentation of Self in Everyday Life*. New York: Doubleday.

Goldie, J. (2012) 'The formation of professional identity in medical students. Considerations of educators', *Medical Teachers*, 34, e641-e648.

Golub, R.M. (2016) 'Medical Education Theme Issues Call for Papers', *Journal of the American Medical Association*, 315(10), 989.

Goodson, I. (1992) *Studying Teachers' Lives*. London: Routledge.

Green, J. and Thorogood, N. (2014) *Qualitative methods for Health Research*. London: Sage.

Greenway, D. (2013) *Shape of Training. Securing the Future of Excellent Patient Care*. London: Shape of Training.

Gundersen, L. (2001) 'Physician burnout', *Annals of Internal Medicine*, 135(2), 145-148.

Hafferty, F.W. and O'Donnell, F. (2014) *The Hidden Curriculum in Health Professions Education*. New Hampshire: Dartmouth College Press.

Hafferty, F.W. and Franks, R. (1994) 'The hidden curriculum, ethics teaching and the structure of medical education', *Academic Medicine*, 69(11), 861-71.

Hafler, J.P., Ownby, A.R., Thompson, B.M., Fasser, C.E., Grigsby, K., Haidet, P., Kahn, M.J., and Hafferty, F.W. (2011) 'Decoding the learning environment of medical education: A hidden curriculum perspective for faculty development', *Academic Medicine*, 86 (4), 440-444.

Hammersley, M. (2012) 'Transcription of speech'. In S. Delamont (Ed) *Handbook of qualitative Research in Education*. Cheltenham: Edward Elgar Publishing

Handley, K., Sturdy, A., Fincham, R. and Clark, T. (2006) 'Within and beyond communities of practice: Making sense of learning through participation, identity and practice', *Journal of Management Studies*, 43(3), 641-653.

Hanbury, A., Prosser, M. and Rickinson, M. (2008) 'The differential impact of UK accredited teaching development programmes on academics' approaches to teaching', *Studies in Higher Education*, 33(4), 143-157.

Hays, R. (2006). *Teaching and Learning in Clinical Settings*. Abingdon: Radcliffe.

Higgs, J. and Cherry, N. (2009) 'Doing qualitative research on practice'. In J. Higgs, D. Hornful and C. Grace (2009) *Writing Qualitative Research on Practice*. Rotterdam: Sense Publishers.

Higham, J. and Steer, P.J. (2004) 'Gender gap in undergraduate experience and performance in obstetrics and gynaecology: analysis of clinical experience logs', *British Medical Journal*, 328, 142.

Higher Education Academy (2011) *The UK Professional Standards Framework for Teaching and Supporting Learning in Higher Education*. York: Higher Education Academy.

Hu, W.C., Thistlewaite, J.E., Weller, J., Gallego, G., Monteith, J and McColl, G.J. (2015) 'It was serendipity' – a qualitative study of academic careers in medical education. *Medical Education*, 49, 1124-1136.

Huwendiek, S., Menino, S., Dern, P., Freidman Ben-David, M., van de Vleuten, C., Longshot, B. and Nicene, C. (2010) 'Expertise, needs and challenges of medical educators: Results of an international web survey'. *Medical Teacher*, 32(11), 912-918.

Illing, J. (2014) 'Thinking about research. Theoretical perspectives, ethics and scholarship' in T. Swanick (Ed) *Understanding Medical Education: Evidence, Theory and Practice*. London: John Wiley.

Kalet, A., Buckvar-Keltz, L., Harnik, V. Monsoon, V., Hubbard, S., Crowe, R., Hyuksoon, S.S. and Yingling, S. (2017) 'Measuring professional identity formation early in medical school', *Medical Teacher*, 39 (3), 255-261.

- Kanter, R. (1977). 'Some effects of proportions on group life: skewed sex ratios and responses to token women', *American Journal of Sociology*, 82(5), 965-990.
- Kerno, S.J. (2008) 'Limitations of communities of practice. Unresolved issues and difficulties in the approach', *Journal of Leadership and Organisational Studies*, 15(1), 69-78.
- Kilminster, S., Downes, J., Gough, B., Murdoch-Eaton, D. and Roberts, T. (2007) 'Women in medicine – is there a problem? A literature review of the changing gender composition, structures and occupational cultures in medicine'. *Medical Education*, 41, 39–49.
- Kinder, B.K. (1985) 'Women and men as surgeons. Are the problems really different?' *Current Surgery*, 42, 100-104.
- Kjeldstadli, K. Tyssen, R., Finset, A., Hem, E., Gude, T., Gronvold, N.T., Ekeberg, O. and Vaglum, P. (2006). 'Life satisfaction and resilience in medical school – a six year longitudinal, nationwide and comparative study'. *BMC Medical Education*, 6, 48.
- Klingensmith, M. and Anderson, K. (2006) 'Educational scholarship as a route to academic promotion: a depiction of surgical education scholars', *American Journal of Surgery*, 191(4), 533-537.
- Kneebone, R. (2002) 'Total internal reflections: an essay on paradigms', *Medical Education*, 36(6), 514-518.
- Kubiak, C., Cameron, S., Conole, G., Fenton-O'Creevy, M., Mylrea, P., Rees, E., and Shreeve, A. (2015) 'Multimembership and identification'. In Wenger-Trayner, E., Fenton-O'Creevy, M., Hutchison, S., Kubiak, C., and Wenger-Trayner, B. (2015) *Learning in Landscapes of Practice*. London: Routledge.
- Kuhlmann, E., Ovseiko, P., Kurmeyer, C., Gutierrez-Lobos, K., Steinbock, S., von Knorring, M., Buchan, A., and Brommels, M. (2017) 'Closing the gender leadership gap: a multi-centre cross country comparison of women in management and leadership in academic health centres in the European Union'. *Human Resources for Health*, 15, 2.
- Kvale, S. and Brinkmann, S. (2009) *InterViews*. Thousand Oaks, California: Sage Publications.
- Lankshear, C. and Knobel, M. (2004) *A Handbook for Teacher Research*. Maidenhead: Open University Press.
- Lave, J. and Wenger, E. (1991) *Situated Learning. Legitimate Peripheral Participation*. Cambridge: Cambridge University Press.
- Lea, M. R. (2005) "'Communities of Practice' in Higher Education. Useful heuristic or educational model?' In D, Barton and K, Tusting (2005) *Beyond Communities of Practice. Language, Power and Social Context*. Cambridge: Cambridge University Press.
- Lempp, H. and Seale, C. (2004) 'The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching', *British Medical Journal*, 329(7469), 770–773.

- Lewington, K. (2012) 'Changes to medical education over the past 20 years', *BMJ Careers* <http://careers.bmj.com/careers/advice/view-article.html?id=20007762> [accessed 3rd Dec 2017].
- Limb, M. (2017) 'The rise of medical entrepreneurs'. *Student BMJ*, doi: 10.1136/sbmj.j1694 [accessed 4th August 2017].
- Lindlof, T.R. and Taylor, B.C. (2002) *Qualitative Communication Research Methods*. Thousand Oaks, CA: Sage.
- Lomax, H. (2013) 'Managing identities' in S. MacKian and J. Simons (2013) *Leading, Managing, Caring. Understanding Leadership and Management in Health and Social Care*. Abingdon: Routledge
- Lown, B.A., Newman, L.R and Hatem, C, J. (2009) 'The personal and professional impact of a fellowship in medical education', *Academic Medicine*, 84 (8), 1089-1097.
- Luker, K. (2008) *Salsa Dancing into the Social Sciences: Research in an Age of Info-Glut*. London: Harvard University Press.
- MacDougall, J. and Drummond, M.J. (2005) 'The development of medical teachers: an enquiry into the learning histories of 10 experienced medical teachers'. *Medical Education*, 39, 1213-1220.
- MacLeod, A. and Frank, B. (2012) 'Feminist pedagogy and medical education. Why not now?' *Medical Education*, 47(1), 11-14.
- MacLure, M. (2001) 'Arguing for your self: Identity as an organising principle in teachers' jobs and lives'. In J. Soler, A. Craft and H. Burgess (2001) *Teacher Development. Exploring Our Own Practice*. London: Paul Chapman Publishing.
- Mariskind, C. (2014) 'Teachers' care in higher education: contesting gendered constructions'. *Gender and Education*, 26(3), 306-320.
- Markakis, K.M., Beckman, H., Suchman, A.L. and Frankel, R.M. (2000) 'The path of professionalism: Cultivating humanistic values and attitudes in residency training'. *Academic Medicine*, 75(2), 141-149.
- Mason, J. (2002) *Qualitative Researching (2nd Ed)*. London: Sage Publications.
- Masunaga, H. and Hitchcock, M.A. (2011) 'How does gender interact with clinical teacher's perceptions of clinical teaching?' *NASPA Journal about Women in Higher Education*. 4(1), 50-72.
- Mattsson, T. (2015) 'Good girls: emphasised femininity as cloning culture in academia'. *Gender and Education*, 27(6), 685-699.
- McAvinia, C., Hanratty, O., Donnelly, R and Harvey, J. (2015) Does accredited professional development for academics improve teaching and learning in higher education?' In F.M.

Ribeiro, Y. Polotis and B. Culum. *New Voices in Higher Education Research and Scholarship*. Hershey, PA: Information Science Reference.

McCray, L.W., Cronholm, P.F., Bogner, H.R., Gallo, J.J., Neil, R.A (2008). 'Resident physician burnout: Is there hope?' *Family Medicine*, 40(9), 626-632.

Measor, L. (1985). 'Interviewing: A strategy in qualitative research'. *Strategies of educational research: Qualitative methods*, 55-77.

Medical Schools Council (2016a) *UK Medical Schools A-Z*
<http://www.medschools.ac.uk/Students/UKMedicalSchools/Pages/UK-Medical-Schools-A-Z.aspx> [accessed 19th Dec 2016].

Medical Schools Council (2016b) *Applying to Medical School*
<http://www.medschools.ac.uk/Students/howtoapply/Pages/default.aspx> [accessed 30th Dec 2016].

Miles, A. and Mezzich, J. (2011) 'The care of the patient and the soul of the clinic. Patient centred medicine as an emergent model of modern clinical practice', *International Journal of Patient Centred Medicine*, 1(2), 207-222.

Molesworth, M., Scullion, R., and Nixon, E. (2011). *The Marketisation of Higher Education and the Student as Consumer*. Oxon: Routledge.

Monrouxe, L.V. (2009) 'Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries', *Current Narratives*, 1, 41-59.

Monrouxe, L.V. (2010) 'Identity, identification and medical education. Why should we care?' *Medical Education*, 44, 40-49.

Monrouxe, L.V. and Poole, G. (2013) 'An onion? Conceptualising and researching identity', *Medical Education*, 47, 425-429.

Monrouxe, L. V and Rees, C.E. (2015) 'Theoretical Perspectives on identity: researching identities in healthcare education'. In J. Cleland and S.J. Durning *Researching Medical Education*. London: John Wiley and Sons.

Morley, L. (2003) *Quality and Power in Higher Education*. Maidenhead, Berkshire: SRHE and Open University Press.

Morton, M.J., Bristol, M.B., Atherton, P.H., Schwab, C.W and Sonnad, S.S. (2008) 'Improving the recruitment and hiring process for women faculty', *Journal of the American College of Surgeons*, 206(6), 1210-1217.

National Committee of Inquiry into Higher Education (NCIHE) (2017) *Higher Education in the Learning Society*. Norwich: Crown Copyright.

Ng, S., Lingard, L and Kennedy, T.J. (2014) 'Qualitative research in medical education. Methodologies and methods'. In T. Swanick (Ed) *Understanding Medical Education: Evidence, Theory and Practice*. London: John Wiley.

- Noy, C. (2008) 'Sampling knowledge: the hermeneutics of snowball sampling in qualitative research', *International Journal of Social Research Methodology*, 11(4): 327-44.
- Paechter, C. (2003a) 'Masculinities and femininities as communities of practice', *Women's Studies International Forum*, 26(1), 69-77.
- Paechter, C. (2003b) 'Learning masculinities and femininities: power/knowledge and legitimate peripheral participation', *Women's Studies International Forum*, 26(1), 541-552.
- Paechter, C. (2006) 'Power, knowledge and embodiment in communities of sex/gender practice', *Women's Studies International Forum*, 29, 13-26.
- Park J., Minor S., Taylor R.A., Vikis E. and Poenaru D. (2005) 'Why are women deterred from general surgery?', *American Journal of Surgery*, 190, 141-6.
- Parsons, D., Hill, I., Holland, J., and Willis, D. (2012) *Impact of Teaching Development Programmes in Higher Education*. York: Higher Education Academy.
- Pereira Gray, D. (1984) 'Minimum standards for training. Selecting general practitioner trainers', *British Medical Journal*, 288, 195-198.
- Pilcher, J., and Whelehan, I. (2004). *50 Key Concepts in Gender Studies*. London: Sage.
- Pirrie, A. (2000) 'Research in medical education: the law of diminishing non-returns', *Medical Education*, 34(5), 333-334.
- Prichard, D., Collins, N., Boohan, M and Wall, C. (2011) 'Junior doctors and undergraduate teaching: the influence of gender on the provision of medical education', *Teaching and Learning in Medicine*, 23(2), 155-160.
- Pugsley, L., Brigley, S., Allery, L. and MacDonald, J. (2008) 'Counting quality because quality counts: differing standards in master's in medical education programmes'. *Medical Teacher*, 30, 80-85.
- Pugsley, L. (2012) 'Walk this way, talk this way. Qualitative research on professional education'. In S. Delamont (Ed) *Handbook of Qualitative Research in Education*. Cheltenham: Edward Elgar Publishing.
- Quine, L. (2002) 'Workplace bullying in junior doctors: questionnaire survey', *British Medical Journal*, 324, 878.
- Qureshi, S. (2015) 'Teaching fellowships for UK foundation doctors', *Medical Teacher*, 37, 90-91.
- Ramazanoglu, C. and Holland, J. (2002) *Feminist Methodologies. Challenges and Choices*. London: Sage.
- Rimmer, A. (2017a) 'Half of foundation trainees now choose not to progress straight to specialty training', *BMJ Careers*.

- Rimmer, A. (2017b) 'Postgraduate training will be more flexible under new standards, say GMC', *BMJ Careers*.
- Risberg, G., Johansson, E.E, Westmas, G and Hamberg, K. (2003) 'Gender in medicine – an issue for women only? A survey of physician teachers' gender attitudes', *International Journal for Equity in Health*, 2, 10.
- Riska, E. (2009) *Gender and medical education* in C. Brosnan and B.S. Turner, *Handbook of the Sociology of Medical Education*. London: Routledge.
- Roberts, D., Morris, G., Crees, A., Slade, T and Jakeman, A. (2014) 'Top tips for a teaching fellowship', *Clinical Teacher*, 11(7), 520-3.
- Roberts, J. (2006) 'Limits to Communities of Practice', *Journal of Management Studies*, 43(3) 623-639.
- Rosenblum, N.D., Kluijmans, M. and ten Cate, O. (2016) 'Professional identity formation and the clinician-scientist: A paradigm for a clinical career combining two distinct disciplines', *Academic Medicine*, 91(12), 1612-1617.
- Royal College of Physicians (2010) *Future Physician: Changing Doctors in Changing Times. Report of a Working Party*. London: RCP.
- Royal College of Physicians (2015) *Life as a Medical Trainee*
<https://www.rcplondon.ac.uk/education-practice/advice/life-medical-trainee> [accessed 28th December 2017].
- Sabel, E., and Archer, J. (2014) 'Medical Education is the ugly duckling of the medical world' and other challenges to medical educators' identity construction: A qualitative study'. *Academic Medicine*, 89, 1474-1480.
- Sandhu, B., Margerison, C., & Holdcroft, A. (2007) 'Women in the UK medical academic workforce', *Medical Education*, 41, 909–914.
- Sargent, P. (2005) 'The gendering of men in early childhood education', *Sex Roles*, 52, 251-259.
- Savigny, H. (2014) 'Women, know your limits: cultural sexism in academia'. *Gender and Education*, 26(7), 794-809.
- Savin- Baden, M. and Howell Major, C. (2013) *Qualitative Methods*. London: Routledge.
- Schofield, S.J., Bradley, S., McRae, C., Nathwani, D. and Dent, J. (2010) 'How we encourage faculty development', *Medical Teacher*, 32, 883-886.
- Seabrook, M. (2004a) 'Clinical students' initial reports of the educational climate in a single medical school', *Medical Education*, 38, 659-669.
- Seabrook, M. (2004b) 'Intimidation in medical education: Students' and teachers' perspectives'. *Studies in Higher Education*, 29, 59–74.

Seidman, I. (2013) *Interviewing as Qualitative Research. 4th Ed.* New York: Teachers College Press.

Sethi, A., Schofield, S., Ajjawi, R., and McAleer, S. (2016) 'How do postgraduate qualifications in medical education impact on health professionals', *Medical Teacher*, 38(2), 162-167.

Sethi, A., Ajjawi, R., McAleer, S. and Schofield, S. (2017) 'Exploring the tensions of being and becoming a medical educator', *BMC Medical Education*, 17, 1-10.

Shepherd, A., McKay, J., and Bowie, P. (2010) 'Training the trainer in general practice: The perceived value of independent peer feedback for learning activities', *Education for Primary Care*, 21, 368-75.

Smith, M.J. (1998) 'Social science as situated practice' in M.J. Smith (1998) *Social Science in Question*. London: Sage Publications.

Spencer, J. (2003) 'Learning and teaching in the clinical environment', *British Medical Journal*, 326(7389), 591-594.

Spradley, J. (1979) *The Ethnographic Interview*. New York: Holt, Rinehart and Winston.

Starr, S., Ferguson, W.J., Haley, H-L., Quirk, M. (2003) 'Community preceptors' views of their identities as teachers', *Academic Medicine* 78(8), 820-825.

Steinert, Y. (2014). 'Developing medical educators. A journey not a destination'. In T. Swanick (Ed) *Understanding Medical Education. Evidence, Theory and Practice*. Chichester: Wiley Blackwell.

Steinert, Y., Mann, K., Centeno, A., Dolmans, D., Spencer, J., Gelula, M. and Prideaux, D. (2006) 'A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education. BEME Guide No.8', *Medical Teacher*, 28(6), 497-526.

Stenfors-Hayes, T., Weurlander, M. Owe Dahlgren, L. & Hut, H. (2010) 'Medical teachers' professional development – perceived barriers and opportunities', *Teaching in Higher Education*, 15(4), 399-408.

Stoddard, H.A. and Brownfield, E.D. (2016) 'Clinician educators as dual professionals: A contemporary reappraisal'. *Academic Medicine*, 91(7), 921-924.

Stone, S., Ellers, B., Homles, D., Orgren, R., Qualters, D. and Thompson, J. (2002) 'Identifying oneself as a teacher. The perceptions of preceptors', *Medical Education*, 36(2), 180-185.

Sundberg, K., Josephson, A., Reeves, S., and Nordquist, J. (2017) 'May I see your ID, please. An explorative study of the professional identity of undergraduate medical education leaders', *BMC Medical Education*, 17, 29

Svirko, A., Lambert, T. and Goldacre, M.J (2013) 'Gender, ethnicity and graduate status, and junior doctors' self-reported preparedness for clinical practice: national questionnaire surveys'. *Journal of the Royal Society of Medicine*, 107 (2), 66-74.

Swanick, T. (2009) 'Teaching the teachers- no longer an optional extra', *British Journal of Hospital Medicine*, 70, 176-7.

Swanick, T. (2014) 'Understanding medical education' In T. Swanick (Ed) *Understanding Medical Education. Evidence, Theory and Practice*. Chichester: Wiley Blackwell.

Tekian, A. and Harris, I. (2012) 'Preparing health professions education leaders worldwide: A description of masters-level programs', *Medical Teacher*, 34(1), 52-8.

Thomas, M.R., Dyrbye, L.N., Huntington, J.L., Lawson, K.L. Novotny, P.J, Sloan, J.A. and Shanefelt, T.D. (2007) 'How do distress and wellbeing relate to medical student empathy? A multicenter study', *Journal of General Internal Medicine*, 22(2), 177-183.

Tsouroufli, M. (2016) 'Gendered pedagogic identities and academic professional in Greek Medical Schools'. *Gender and Education*. doi 10.1080/09540253.2016.1262008.

Tsouroufli, M., Rees, C.E., Monrouxe, L.V. and Sundaram, V. (2011) 'Gender, identities and intersectionality in medical education research', *Medical Education*, 45, 213-216.

Tucker, C.R. (2017) 'If medical education was a discipline, she would have five core competencies' *Medical Teacher*, 39(7), 783-784.

Twigg, V. (2017) 'Training in the NHS needs to be tailored to 'Generation Y''. *BMJ Opinion*, 22nd June 2017.

UK Foundation Programme Office (2017) *About the Programme*
<http://www.foundationprogramme.nhs.uk/pages/home/about-the-foundation-programme>
[accessed 6th December 2017].

Van de Vleuten, C.P.M. (2014) 'Medical education research: a vibrant community of research and education practice', *Medical Education*, 48, 761-7.

Van de Berg, J.W., Verberg, C.P.M., Scherpbier, A.J.J.A., Jaarsma, A.D.C, and Lombarts, K.M.J.M.H. (2017) 'Is being a medical educator a lonely business? The essence of social support', *Medical Education*, 51(3):302-315.

Van Winsen >, Wijesuriya, R. and Nicholson, S. (2017) 'Intercalating in medical education; is it more valuable than other intercalated degrees?' *MedEdPublish*, 6(3), 31.

Verdonk, P., Harting, A and Largo-Janssen, T.L.M. (2007) 'Does equal education generate equal attitudes? Gender differences in medical students' attitudes toward the ideal physician', *Teaching and Learning in Medicine*, 19(1), 9-13.

Wald, H.S. (2015) 'Professional identity (trans) formation in medical education: Reflection, relationship and resilience', *Academic Medicine*, 90(6), 701-706.

- Walford, G. (2001) *Doing Qualitative Educational Research. A Personal Guide to the Research Process*. London: Continuum.
- Waters, M., and Wall, D. (2007) 'Educational CPD: how UK GP trainers develop themselves as teachers', *Medical Teacher*, 29, e160-169.
- Weiss, R.S. (1994) *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press.
- Wenger, E. (1998) *Communities of Practice*. Cambridge: Cambridge University Press.
- Wenger-Trayner, E., Fenton-O'Creevy, M., Hutchison, S., Kubiak, C., and Wenger-Trayner, B. (2015) *Learning in Landscapes of Practice*. London: Routledge.
- Wenger, E., McDermott, R., and Snyder, W.M. (2002) *Cultivating Communities of Practice* Boston, Massachusetts: Harvard Business School Press.
- Wenger-Trayner, E. and Wenger-Trayner, B. (2015) *Communities of Practice: A Brief Introduction* available from <http://wenger-trayner.com/wp-content/uploads/2015/04/07-Brief-introduction-to-communities-of-practice.pdf> [accessed 10th December 2017].
- Weurlander, M. and Stenfors-Hayes, T. (2008) 'Developing medical teachers' thinking and practice: impact of a staff development course', *Higher Education Research and Development*, 27(2), 143-153.
- Wilson, S., Denison, A.R. and McKenzie, H. (2008) 'A survey of clinical teaching fellowships in UK medical schools', *Medical Education*, 42(2), 170-175.
- Winch, C. (2004) 'What do teachers need to know about teaching? A critical examination of the occupational knowledge of teachers', *British Journal of Educational Studies*, 52(2), 18-196.
- Wing Sue, D. (2010) *Micro Aggressions in Everyday Life: Race, Gender and Sexual Orientation*. New Jersey: John Wiley and Sons.
- Wojtczak, A. (2013) *A History of AMEE 1972-2009*. Dundee: AMEE.
- Woolf, K. (2006) 'Surely this can't be proper research? Experiences of a novice qualitative researcher', *Clinical Teacher*, 3(1), 19-22.

Appendices

1. Research diary extracts
2. Confirmation of ethical approval from King's College, London
3. Confirmation of ethical approval from Imperial College, London
4. Recruitment email
5. Participant information sheet
6. Consent form
7. Interview schedule
8. Example of coded interview transcript (extract)
9. Example of memo

1. Research diary extracts

27th May 2016

I have spent the last month getting ethical approval for my project as well as negotiating access with course leads.

At times this has felt an onerous task but the process of gaining ethical approval has made me really think about my research and the details of say, the recruitment of participants and snowballing sampling. Who was I going to ask and when? In terms of snowballing sampling, how was I going to encourage participants to nominate other potential participants?

Although my project was low risk, I felt a particular concern to get things 'right'. In October 2015 I had taken on a new role as the lead for medical education research in the Department of Primary Care. I was therefore involved in advising people about research and gaining appropriate ethical approval for projects. I therefore felt it was important in terms of this role and my credibility, that any research I did had been given the appropriate approvals. This meant that negotiating what ethical approval I needed took some time and I wanted to be confident in the choices I had made.

Negotiating access – things I thought about.

- Asking for access to the MEd graduates from three courses was important in terms of being able to recruit participants.
- I also thought that some of these people might know me and had been taught by me. Whilst I was very concerned about minimising coercion, I also thought that some personal contact might incentivise potential participants. I can imagine that unless you had lots of time, it would be difficult to give up time for and be interviewed someone you didn't know.
- In terms of contacting the relevant course leads, I took quite a bit of time to craft the email. I thought carefully about how I, as a course lead, might feel about receiving such an email. Was the researcher going to ask about my course? Would it be identifiable? How might criticisms of the course be handled? If I said yes to this researcher would I feel I had to say yes to other researchers who may ask for access? I therefore crafted an email outlining my research and reassuring the course leads that I would not be asking about their course specifically and that it would not be identifiable in any write up. The response from three course leads was very swift and straightforward – no problems.

I leave my supervision meeting relieved. I've managed to have some things to talk about and don't think I made a complete fool of myself. I also feel a bit clearer about some of the issues that had been troubling me. AC suggests a couple of theses to look at and I head off to the library, reassuring him that seeking these out will be a straightforward task. Of course I was wrong – the librarian can't find them on the system and isn't even sure which library they are stored at. She promises to look into this and email me.

I have a friend visit for the weekend. I know I have been neglecting friends and family which feels a necessary part of doctoral study. However, this has been in the diary for some time and I've not seen her since a quick dinner when she was in London for work 10 months ago. I do no EdD work but do share with her my concerns about the amount of work I need to do including the promise to write a chapter for a forthcoming book - the deadline for a chapter overview is looming. She feels guilty for taking up my time and I feel guilty for mentioning it. She leaves late on Sunday afternoon as planned, and I spend the remainder of the evening writing the overview.

The following two weeks pass in a blur of teaching, marking, meetings, and admin tasks. I spend several evenings at events at work and struggle to get much done in the other evenings. I do craft an email to K's course administrator asking for her help with recruiting participants. I save it to my drafts folder. What is my reluctance to send it? I worry about spelling errors, open it and check for typos. I worry what she will think. Will she be ok with me asking for help? Will she see it as a burden or an inappropriate request? I close the email and promise myself to send it the following day.

It's Friday. I open my diary and swear. 10 days until my next supervision meeting and what have I to show? I have no appointments in my calendar and so decide to spend some time sorting out recruitment. I open the saved email to the course administrator and my finger hovers over the send button. I hesitate and open the attached participant information sheet double checking it for errors. It's ok I think. I hit send and turn my attention to another task. An email pops up. It's from the course administrator. Hi! It says. I've sent out your email to our final year students. She signs off 'Good luck! ☺'. I'm relieved – that was quick and seemed straightforward. Oh, but she's only sent it to final year students and not graduates. I hit reply. Might you be able to send it to your graduates as well?' I ask wondering if she can sense my anxiety. As long as it's not too much trouble of course. I hit send knowing that agonising over the email won't help. Again she replies promptly – No problem! I just hadn't seen that bit in your email. I'm relieved.

By mid-afternoon, four potential participants have contacted me. I feel a mixture of relief, gratitude and concern. I now need to sort out when and where to interview them, trying to navigate busy schedules (both theirs and mine). I'm not sure I will get these interviews done, if any, before my supervision meeting. However, I decide that a well-crafted response is preferable to a quick one and therefore decide to follow up these emails after work.

On the bus on the way home I think about what motivates people to volunteer for my study. AC suggests that people like to talk about themselves. I think he's right and hope that they don't feel obligated in some way. I reassure myself that two of the participants don't even know me, and knowing the other two participants I think that they would both be capable of ignoring an email.

I know I need to do some writing this weekend but don't know where to start. I begin with this diary entry.

17th June 2016

As I walked across the park, back to the office, I reflected on the previous 2 interviews. Both on the process (too many stumbles, repeated questions, not understandable etc.) but also on some of the responses. Something that intrigued me was that whilst both of these interviewees acknowledged the relative low status of education in comparison to other areas of their work e.g. clinical skills, research etc. they seemed relatively comfortable with this. They didn't reveal any particular tensions with trying to manage these different aspects of their work and I wondered why this might have been. One possible explanation was that they both had well developed research careers (in one case a relatively high profile one) and as both were working at top London hospitals, I assumed well developed and highly skilled clinical practice. I wondered if this made it easier to be involved in education. Was this somewhat analogous to the idea from the performing arts of the 'triple threat'? That is someone who is highly skilled at singing, dancing and acting. Were these participants the equivalent of a 'triple threat' within medical education?

12th July 2016

Post interview reflections

Particularly difficult interview. Didn't seem to provide a lot of detail ?phone interview? Need to ask for more examples next time. Perhaps did not have as wide an educational role as some of the others e.g. very little undergrad, mainly supervision of trainee doctors etc. Need to think about how to ask questions and prompt in order to delve a bit deeper....

24th August 2016

Post interview reflections

.....lots to discuss in this interview. Realise that I should give more time to participant. Really helpful to get them to say what they thought I would ask about – lots of rich detail gained. Will definitely use this in future interviews - this seems much more useful than 'is there anything else you want to ask?'.....

2. Confirmation of ethical approval from King's College, London

13 April 2016

Dear Joanna

LRS15/162213 Exploring professional identities of medical educators

Thank you for submitting your application for the above project. I am pleased to inform you that your application has now be approved with the provisos indicated at the end of this letter. All changes must be made before data collection commences.

The Committee does not need to see evidence of these changes, however supervisors are responsible for ensuring that students implement any requested changes before data collection commences.

Please ensure that you follow all relevant guidance as laid out in the King's College London Guidelines on Good Practice in Academic Research:

<http://www.kcl.ac.uk/college/policyzone/assets/files/research/good%20practice%20Sept%2009%20FINAL.pdf>

Ethical approval has been granted for a period of one year from 13 April 2016 . You will not be sent a reminder when your approval has lapsed and if you require an extension you should complete a modification request, details of which can be found here:

<http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx>

Any unforeseen ethical problems arising during the course of the project should be reported to the panel Chair, via the Research Ethics Office. Please note that we may, for the purposes of audit, contact you to ascertain the status of your research.

We wish you every success with your research. Yours sincerely,
E&M Research Ethics Panel REP Reviewer

Major Issues (will require substantial consideration by the applicant before approval can be granted)

Minor Issues related to application (the reviewer should identify the relevant section number before each comment)

Minor Issues related to recruitment documents

Consent form point 6 – In the brackets, please state that the data would not be identified (as indicated earlier).

Advice and Comments (do not have to be adhered to, but may help to improve the research)

3. Confirmation of ethical approval from Imperial College, London

Fri 13/05/2016, 16:27

Dear Jo,

Many thanks for your recent EERP application which has now been reviewed.

We understand that this low risk study has already been given ethical approval at Kings College where the project is based. Ethical approval is sought at Imperial College as some participants are connected to this institution and some interviews may be performed here.

Our reviewers noted that relevant steps have been taken to avoid contentious issues and avoid the risk of bias. Recruitment and selection have been thought through carefully and care has been taken to mitigate against any coercion issues. This is a well-planned project and **we are therefore pleased to confirm that your application has been approved.**

Please remember that ethical approval is given for the work as detailed in this application. Should you wish to change your research methods or approach in any significant way (e.g. changing methods, participants or recruitment); you will need to reapply for ethical approval of the changes. If this is the case, please contact us in the first instance for further information.

We wish you the very best with your research.

Best wishes

Education Ethics team

edethics@imperial.ac.uk

www.imperial.ac.uk/research-and-innovation/support-for-staff/education-ethics

4. Recruitment email

Exploring professional identities of medical educators –
Recruitment email.

Dear XXXXX

I am a Principal Teaching Fellow at Imperial College London and I am currently completing an EdD at King's College London and as part of my course need to undertake a Research Based Thesis (RBT). I am emailing to invite you to take part in my research which aims to better understand the professional identity development of medical educators. I am inviting those who have complete or are in their final year of a Master's in medical/surgical/clinical education to take part on one to one semi structured interviews (lasting no longer than 60 mins). The research has received ethical approval from King's College London (application number XXXXX).

For further information, please read the attached participant information sheet. Having read this, if you would like to take part in the research or have any further questions, please contact me at Joanna.horsburgh@kcl.ac.uk

Thank you for taking the time to read this and I look forward to hearing from you.

Kind regards,
Jo Horsburgh
EdD student, King's College London.

INFORMATION SHEET FOR PARTICIPANTS

King's College London REC Reference: LRS – 15/16-2213
Imperial College London EERP Reference: EERP 1516-012



YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study

Exploring professional identities of medical educators.

Invitation Paragraph

I would like to invite you to participate in this research project which forms part of my EdD research. You should only participate if you want to; choosing not to take part will not disadvantage you in anyway. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of the study is to better understand the professional identity development of medical educators, using completion of a Master's in medical or clinical education (or similar) as an indicator of ongoing commitment to a professional educator role. I am particularly interested in how medical educators view their own identity as well as how they think they may be viewed by others, and the implications of these perceptions on practice.

Why have I been invited to take part?

I am inviting medically qualified graduates and students from three Master's in education courses to take part as well as those nominated by existing participants who meet the inclusion criteria of having completed or be completing a Master's in medical or clinical education (or similar).

Do I have to take part?

Participation is voluntary. You do not have to take part. You should read this information sheet and if you have any questions you should ask the research team.

What will happen to me if I take part?

If you decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. I will then discuss the interview procedure with you and arrange to interview you in a private place (for confidentiality reasons) either in person, via Skype or telephone

The interview will take approximately 45-60mins and be based on an interview topic guide but it is designed to be flexible so as to meet your needs. The interview will be recorded, subject to your permission. All recordings of data on audio equipment will be deleted after transcription. You will be sent a copy of the interview transcript for verification. Even if you have decided to take part, you are still free to stop your participation at any time during the interview and to have research data/information relating to you withdrawn without giving any reason up to 31st January 2017.

What are the possible benefits and risks of taking part?

The information I get from the study will help further understand the professional identity development of medical educators. Understanding professional identity is important in order to best support those taking on a medical educator role including those undertaking a Master's in medical or clinical education (or similar). The finding will be disseminated to the wider medical education community and will be of particular interest and relevance to MEd course leads. Furthermore, I will provide you with a summary of a final report describing the main findings. The main disadvantage to taking part in the study is that you will be donating around an hour of your time to take part.

There are no foreseeable risks in participating in the study

Will my taking part be kept confidential?

What is said in the interview is regarded as strictly confidential and will be held securely until the research is finished. The audio recordings of the interviews may be sent to an external agency for transcription. All data for analysis will be anonymised. In reporting on the research findings I will not reveal the names of any participants, the Master's course you completed or any other identifying information.

The UK Data Protection Act 1998 will apply to all information gathered within the interviews and held on password locked computer files and locked cabinets. No data will be accessed by anyone other than me; and anonymity of the material will be protected by using pseudonyms.

How is the project being funded?

The project is being funded by the researcher. The study has been approved by the King's College London Research Ethics Committee and also the Imperial College Education Ethics Review Process

What will happen to the results of the study?

I will produce a final report summarising the main findings, which will be sent to you. I also plan to disseminate the research findings through publication and conferences within the UK and internationally.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Jo Horsburgh

joanna.horsburgh@kcl.ac.uk

Department of Education and Professional Studies
King's College London
Waterloo Bridge Wing
Franklin-Wilkins Building
Waterloo Road
London
SE1 9NH

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Prof Alan Cribb
Department of Education and Professional Studies
King's College London
Waterloo Bridge Wing
Franklin-Wilkins Building
Waterloo Road
London
SE1 9NH
Tel: +44 (0)20 7848 3151
alan.cribb@kcl.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

6. Consent form

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Title of Study: Exploring professional identities of medical educators.

King's College Research Ethics Committee Ref: LRS15/162213

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes mean that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element I may be deemed ineligible for the study.

Please tick or initial

☐

Please tick or initial

1. ***I confirm that I have read and understood the information sheet dated [Version 1 15.03.16] for the above study. I have had the opportunity to consider the information and asked questions which have been answered satisfactorily.**
2. ***I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to 31st January 2017**
3. ***I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the UK Data Protection Act 1998.**
4. ***I understand that my information may be subject to review by responsible individuals from the College for monitoring and audit purposes.**
5. **I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications**

☐☐☐☐☐

1. I agree that the research team may use my data for future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. (In such cases, as with this project, data would not be identifiable in any report). ☐
2. I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. ☐
3. I consent to my interview being audio recorded. ☐
4. I understand that I must not take part if I fall under the exclusion criteria as detailed in the information sheet and explained to me by the researcher. ☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

7. Interview schedule

Exploring the professional identity development of medical educators – Interview Aide Memoire

Introduction

Introduce myself and thank interviewee for their participation

Check audio recording equipment

Outline interview structure and process –

- 40-50 minutes
- Audio recorded
- Transcribed – emailed to interviewee for verification

Explain that I will be asking for examples and illustrations. These are useful in terms of explaining to those reading the research.

Section 1 *(aim to build rapport, get interviewee used to answering questions)*

Can you tell me about your professional role and what teaching/education you are involved in?

Prompt questions – UG/PG, course leadership, pastoral role etc.

Can you tell me a bit about the MEd you completed and your reasons for doing so?

Prompt questions – format of the course e.g. face to face, distance, online?

motivations for doing the course? Did your motivations change at all?

Section 2 *(aim to build on answers provided in questionnaire. The specifics of these questions will depend on answers provided in questionnaire)*

How do you see yourself as a teacher? What sort of teacher are you?

Prompt questions – style, role, relationship to learners?

What are the things that have influenced your view of yourself as a teacher/educator?

Prompt questions – e.g. role models, feedback from students, completing a MEd Can you give an example of how these factors have changed your view?

What are the similarities and differences between you and your colleagues regarding your views on education?

Is there a hierarchy of activities or skills e.g. research, clinical skills, medical knowledge? Where does education fit into that hierarchy?

Prompt questions – is this the same or different to your colleagues?

The literature suggests that there may be differences in how males and females approach their education role. Does this resonate with you at all?

Prompt question – do you think being male or female would change your experience?

Section 3 *(aim to provide interviewee to provide any additional information and ask any questions they have)*

Is there anything I haven't asked about that you would like to mention?

Do you have any questions that you would like to ask?

Thank you very much for your time and help with this project. I will email you a copy of this interview transcript and you can make any changes that you feel necessary.

8. Example of coded interview transcript (extract)

house - junior doctor.
Currently time out as teaching fellow
Curric design. Teaching resp. ethics & law.

1 Interview Transcript 27.9.16 *Did med as part of UG.*

2 I = Interviewer P = Participant *Interesting comments about originally wanting to be a teacher.*

3 I My first question is, could I ask you just to say a little bit what teaching and

4 education you're doing at the moment.

5 P Ok, so my role is, I have three roles at the moment, is how I would see my education

6 role. So I work in the international curriculum development side so that is my application of

7 theories, so I know you know this but, my application of theory that I learnt in my Masters

8 and applying that to the course in terms of learning objectives, course structure, modality,

9 assessment, writing MCQs or SBAs and advising on assessment strategies. And I'm within a *curric dev.*

10 team doing that. My other role is within medical ethics and law and so that is more front

11 line, resource delivery just for my course in terms of developing an iBook, a course guide, *Postgrad teachu*

12 teaching, so small group teaching, lecture based work. Also tutoring on small group teaching

13 for foundation doctors who are coming to teach our F3s and then also managing that *Range of teach & contexts.*

14 course.

15 I And is that a course for undergraduates or postgraduates?

16 P So it's FYs who teach our year 3 students, so it's kind of a mixture. So its peer

17 assisted learning but with a more peer gap really. So we go out and train the FYs on teaching

18 skills so we don't have any rogue ones (laughs) teaching our year 3s. *Fac dev role*

19 I So you are teaching the foundation doctors rather than directly teaching the year 3s

20 yourself.

21 P Yes, in that course. But I do then teach them in the ethics and law fellow role. So it's

22 a bit of both. And then I'm also a junior doctor on the wards so then I teach medical *UG teachers*

23 students that drift in and drift away (laughs). When we see them in the office, I try and

24 nurture them towards something that's a bit more productive than sometimes following the *approach to teaching*

25 surgeons around all day.

26 I Ok, great. So that's quite a range of different things that you are doing isn't it?

27 P That's why I look so tired! (laughs) *Outcome/result.*

28 I And before you took on your education fellow roles, were you always quite involved
29 in education and teaching or was that quite a recent thing?

30 P Yeah, so it just really happened. So before I did my Master's I wasn't really that
31 involved. I did the classic teddy bear hospital and we went and did outreach work in schools. *As UG student*
32 And I really enjoyed it and part of me always wanted to be a teacher but I didn't feel *involved in teaching*
33 academic enough to say be a secondary school teacher because found secondary school
34 quite hard. And I thought primary school, you have to know loads of different things so
35 there's no chance I'm doing that! (laughs). And so I went and did medicine and I realised *conception of teaching*
36 that a lot of your role is actually educational in terms of patient contact, you're teaching *understanding of role of dr.*
37 them about their disease or educating them about why you're doing a procedure. And I
38 thought, I quite like this I quite like breaking down concepts. So then I found medical school, *Engagement*
39 again, quite hard, so when I got to foundation year and realised that it's actually doable and *challenge of learning*
40 there are things that I could actually do to help and got into my foundation years I decide to
41 take on a lot of educational projects in different domains. So we ran the classic OSCEs for
42 medical students, I was involved in MDT teaching, so I used to teach on the ALERT course as
43 I felt quite passionately that a lot of problems in the hospital were not due to people trying *Edu to problem solve*
44 to cause a problem but they just don't understand. And no one sits down and says, the
45 reason I need this oxygen now is because this is the consequence. Or this is the reason I
46 need that ECG and why I'm not doing it myself. But no one has the time to say that
47 anymore. So that's something I felt really passionate about. And then that just grew. That's
48 like all things I think and then once you've done one thing someone will approach you for *continue in ed.*
49 another and you think, that sounds fun. So we did a few things. So we then did a national
50 conference which was really fun but something that I felt hugely passionate about. Because
51 we all have to get points for our CV and the way those are appointed is in a scale. So it says, *CV-strategic approach*
52 have you done local level, national or international. And everyone thinks you need to do
53 these projects which are really changing the face of medicine, and actually at our level we
54 see things on the ward that are really important but because they have been done before
55 or... they don't do them. So we set up a national conference just for junior doctors to come *Cont.*
56 and present their project that made an impact on the wards. Not internationally, not *Peer teaching*
57 changing it, but come and educate each other. And there were some amazing things. There
58 was one, a doctor had changed the angle at which patients were fed and he has reduced all

59 aspiration pneumonias on his ward. And that's amazing. And that meant he could come and
 60 teach other doctors about that. But that was never something that world leaders would
 61 listen to. So that was my kinds of role. Front line teaching on the ward, organisational *Range of educational activities*
 62 teaching and then MDT and other organisational teaching. But never, course structure or
 63 making a difference. I was just kind of working with opportunities I had. So that was why I *Don't play role in education*
 64 was excited when I got the fellow role that meant I could pair my Master's education with
 65 my enthusiasm from my foundation years into something hopefully that would combine
 66 them both.

67 I Great, thank you. And in comparison to maybe your junior doctor colleagues would
 68 you say that you do more education and teaching than other people who are at the same
 69 level of training, or less or about the same.

70 P Yes. So I do a lot more than my junior doctor colleagues. I think that's changed, I *↑ edu.*
 71 really feel that's changed, even from last year talking to the new clinical fellows this year.

72 And I knew that from talking to my boss who I work with now because at the interview I said
 73 I'm aware that clinical I'm quite young and they said that's fine, the face of education is now *Changing face of education*
 74 changing, we now recognise younger educators as having a bit more of a value than we first
 75 thought they did. And for me it's something that I worry about losing. Because I can already *Role of educator*
 76 sense I'm four year post medical school now and I can already sense that I'm losing what I,
 77 three years ago knew really well about the experience of medical students. So in terms my
 78 junior doctors colleagues I would say that they do more teaching, front line on the wards *Diff edu role to jnr dr colleagues*
 79 because they are there. In terms of education and strategy and structuring that teaching so
 80 it's actually sustainable, targeted and will make a big difference to the students rather than
 81 just a flash impact, I would say that I have more of a role in that.

82 I And you said about how before you went into medicine you maybe thought about
 83 becoming a teacher, what, and I guess that given that you do more education stuff than
 84 some other people at the same or similar level of training, what motivates you to that or
 85 what interests you in that aspect...?

86 P So I think it was mainly because I found medical school quite hard. I got very lost in *Motivation to teach*
 87 the curriculum, there was a lot to learn and I used to go onto the wards and think, oh I don't
 88 know what I'm meant to be doing, I don't know what my place is here, and I think for me,

Challenge of learning in clinical settings

9. Example of memos

Zero draft of Result ch. on Gender.

Yes - John - positivist view applies to men.
Didactic teaching

(p9) Judith - men more confident
women more comfortable dealing with uncertainty
Observing trainees giving lectures - men more confident
& definite
'Girls' better at reflection - although gave example
counter to this.

Diff to expectations

Namh - expected to see women more 'cyclical' - but this isn't
what she saw. (P11)

(P10) - asked if there was link b/w this question & one on status
How located within broader context of more women qual
in med & other profs.

No

Neil - all teachers are σ^2 , don't seem them teach

Claire - maj of ed are f (p9)

Jackie - p9 - I don't think so.

Status of education

Previous lit suggest that education has a lower status
How interviews suggest more complexity than this

Eg.

Helena - lowly GP work compared with structure
& status of teaching in med school.

Natasha - different types of educational activities
have high & low status.

clinical teaching
lecturing

→ eg admin/course
organisation

Jason - despite Psych & Ed being similar,
Ed still as low status